

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 18332 | | | | | | | | | |
| Item 6 Film 408 1/6/69 kk | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR M | |
| BERTHA SOPHIA ASENDORF | | | | | | Dec. 28 1968 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | White | | Aug. 30, 1883 | | 85 84 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Maryland | | U. S. A. | | | | Washington | | Own Home | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Williamsport | | Homewood Church Home | | Housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Baltimore | | Baltimore | | X | | 2128 W. Lexington St. | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| John Sauer | | | Sophia Wagner | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| no | | -- | | 212-09-1264B Mark G. Wagner, Supt., 2750 Va. Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Hypertensive CV Dis</u> | | | | | | | | | |
| 4120 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) _____ | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 443X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-15-66 to 12-28 1968, that (I) (we) last saw the deceased alive on 12-26 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Robert P. Conrad | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 12-29-68 | |
| 22d. PHYSICIAN'S NAME (Type) Robert P. Conrad | | | | | | 22e. ADDRESS 137 W. Washington Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 12/21/68 | | Loudon Park Cemetery | | Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home, Inc. | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 31 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

1932

Dec. 25 1932

Jul. 21, 1932

Washington

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) LILLIE | | | First MAE | | | Middle ATKINSON | | | 20. DATE OF DEATH Month DECEMBER Day 29 Year 68 | | | 2b. HOUR M | |
| 3. SEX FEMALE | | | 4. RACE WHITE | | | 5. DATE OF BIRTH MAY 26, 1896 | | | 6. AGE (In years lost birthday) 72 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) ALABAMA | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH WASHINGTON | | | Md. | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLERICAL WORK | | | 12b. KIND OF BUSINESS OR INDUSTRY OFFICE | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY WASHINGTON | | | 13c. CITY OR TOWN HAGERSTOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 2118 HILLDALE ROAD | |
| 14. FATHER'S NAME First JAMES | | | Middle FLEMING | | | 15. MOTHER'S MAIDEN NAME First LILLIE | | | Middle HAYES | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO | | | 16b. SOCIAL SECURITY NO. 419-30-3008A | | | 17. INFORMANT MRS PAUL WINN | | | 2118 Address HILLDALE RD. | | | HAGERSTOWN, MARYLAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute Myocardial Infarction | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Coronary sclerosis | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Cardio Dis. | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| Hypertensive cardio Dis. | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1 Sept 1966 , to date , 19 68 , that (I) (we) last saw the deceased alive on 3 Nov 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Richard T Binford DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | | |
| 22c. DATE SIGNED 12/30/68 | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) RICHARD T BINFORD, M.D. | | | 22e. ADDRESS 1135 POTOMAC AVE., HAGERSTOWN, MD. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL-REMOVAL | | | 23b. DATE 1/2/69 | | | 23c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY | | | 23d. LOCATION (City or Town) (County) (State) BIRMINGHAM, JEFFERSON, ALA. | | | | |
| 24. FUNERAL DIRECTOR Charles M. Rouse | | | ADDRESS HAGERSTOWN, MARYLAND | | | 25a. REC'D BY REGISTRAR JAN 2 1969 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | |
|--|------------------|-----------------------------------|---|-----------------------------------|--|---|--|--|---|--|--|--|---------------|-----------|--------------|--------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First NELSON | | | Middle RANDALL | | | Last BARNES | | | 2a. DATE KNOWN OF DEATH | Month DEC. | Day 17 | Year 1968 | 2b. HOUR 6:22 M |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH OCT. 28, 1915 | 6. AGE (in years last birthday) 53 YRS. | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD Month 12 Day 17 Year 1968 | | | 2d. HOUR 9:12 M | | | | | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. COUNTY OF DEATH WASHINGTON Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 17 N MULBERRY ST. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) COOK | | | 12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY WASHINGTON | | | 13c. CITY OR TOWN HAGERSTOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 17 N. MULBERRY ST. | | | | | |
| 14. FATHER'S NAME First DUDLEY Middle N Last BARNES | | | 15. MOTHER'S MAIDEN NAME First MARY Middle E Last KREITZ | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) WW II 214-09-9682 | | | 17. INFORMANT DUDLEY P BARNES | | | ADDRESS HAGERSTOWN, MARYLAND | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF pulmonary embolism, secondary branch of left pulmonary artery and broncho- (b) pneumonia, left lung and fatty DUE TO, OR AS A CONSEQUENCE OF metamorphosis of liver, marked (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 days 4-6 days 10-15 yrs. | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | County | | State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Schwartz W D H O III EXAMINER'S NAME (Type) E.W. DITTO, III, M.D. 215 W WASHINGTON | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 12/18/68 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE 12/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY | | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASHINGTON, MD. | | | | | | | | |
| 24. FUNERAL DIRECTOR Charles M. Rausch ADDRESS HAGERSTOWN, MARYLAND | | | | | | 25a. REC'D BY REGISTRAR DEC 20 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | |

1831



UNITED STATES DEPARTMENT OF THE INTERIOR

1831



DEC 2 1830

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove far paper poppers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18335 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 18348 | |
|--|--|---|---|---|--|
| CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year |
| BLARENCE WILLIAM BARNHART | | | | | December 13 1968 |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | 2b. HOUR |
| MALE | White | April 10, 1896 | | 72 YRS. | 40 MIN. |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH | | |
| Lancaster Co., Pa. | U.S.A. | | Washington County Md. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Williamsport | Williamsport Sanitarium | | Wood Worker | Furniture | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | 13b. CITY OR TOWN | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | | |
| Maryland | Washington Hagerstown | | 2423 Virginia Ave. | | |
| 14. FATHER'S NAME | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | First Middle Last |
| Luther M Barnhart | | | | Susan A Staumbaugh | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | Address | |
| No | 214-09-0666A | DeLmont BARNHART | | 2423 Virginia Ave Hager, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke | | | | | |
| 4369 DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 334x | | | | | |
| (b) General arteriosclerosis | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| Metastatic Cancer of Right Lung | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION | Street or R.F.D. No. | City or Town | County State |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | 12-14-68 | |
| PRINCE ROSILLO | | 580 Northern Ave. Hager | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
| Burial | 12/15/68 | Rest Haven Cemetery | Hagerstown-Washington-Md. | | |
| 24. FUNERAL DIRECTOR | ADDRESS | | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | |
| Wm. G. Horst | Rest Haven Funeral Chapel Hagerstown, Md. | | DATE DEC 18 1968 | J Charles Judge | |

MEDICAL CERTIFICATION

General
 Director
 Bureau of Land Management

12-14-61
 12-14-61
 12-14-61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|--|--|--|---|--|--|----------------------------------|-----------------------------------|--------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| Walter Mathias Beitler, Sr. | | | | | | December 15 1968 | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | White | | July 15, 1888 | | | 80 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Halfway Wash. Co. Md. | | USA | | | | Washington Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | | Washington Co. Hospital | | | Car Inspector | | | Railroad | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | |
| Maryland | | | | Boonsboro | | | | 27 Potomac St. | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| John Samuel Beitler | | | Ella Nora Kahoe | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | |
| No | | | | 705-10-4747 | | Mrs. Eva A. Beitler 27 Potomac St. Boonsboro, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> | | | | | | | | | | | SEVERAL | |
| 486X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | DAYS- ABOUT | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 493X | | | | | | | | | | | 3-4 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>UREMIA</u> | | | | | | | | | | | | |
| <u>ARTERIOSCLEROTIC HEART DISEASE SEVERE & CONGESTIVE FAILURE AND</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 11, 1968</u> , to <u>Dec 15, 1968</u> , that (I) (we) lost the deceased alive on <u>Dec 15</u> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Quamir</u> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>12/17/68</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>RIZALITO AMARILLO</u> | | | | | | 22e. ADDRESS <u>120 W. MAIN ST SHARPSBURG MD</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | |
| Burial | | 12/18/68 | | Rest Haven Cemetery | | Hagerstown-Washington-Md. | | | | | | |
| 24. FUNERAL DIRECTOR <u>Wm. C. Horst</u> | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Rest Haven Funeral Chapel Hagerstown, Md. | | | | | | DATE <u>DEC 20 1968</u> | | <u>J. Charles Judge</u> | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18337 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18350 | | | | | | | | | |
|--|--|--|------------------------------|--|--|--|--|--|---------------------------------|---|--|-----------------------------|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last | | | | | | | | | | 2a. DATE OF DEATH Month Day Year | | | | | | | | | | 2b. HOUR P.M. | | | | | | | | | |
| NELLIE M. BITNER | | | | | | | | | | Dec. Month 19 Day 1968 | | | | | | | | | | 12:45 P.M. | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | | | | |
| FEMALE | | | WHITE | | | 2/22/1905 | | | 63 YRS. | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| MD. | | | U.S.A. | | | | | | WASHINGTON Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| HAGERSTOWN | | | | | WASH. Co. Hospital | | | | | Housewife | | | | | Home | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| MD. | | | | | WASH. | | | | | Hagerstown | | | | | YES | | | | | 1630 PARK Rd. | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| Daniel Raley | | | | | UNKNOWN | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | Glen R. Bitner - Hagerstown, Md. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis | | | | | | | | | | | | | | | 1 day. | | | | | | | | | | | | | | |
| 5321 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 5477 (b) Ruptured duodenal ulcer. | | | | | | | | | | | | | | | 1-2 days. | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chronic lymphocytic leukemia. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 57, to Sept 68, that (I) (we) lost soul the deceased alive on 19 Dec 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | |
| Richard T. Binford M.D. | | | | | | | | | | 12/20/68 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| Richard T. Binford M.D. | | | | | | | | | | 1135 Potomac Ave. - Hagerstown, Md. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Burial | | | | | 12/22/68 | | | | | Cedar Hill Cem. | | | | | Greencastle, PA. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | |
| A.E. Minnich - Greencastle, PA. | | | | | | | | | | DEC 23 1968 | | | | | Charles Judge | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR-113
30M REV. 7-68

| 18333 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18351 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|-----------------|--|--|------------------|--|--|--|--|-----------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| Milton Reichard Bloom | | | | | | | | | | December 10, 1968 | | | | | | | | | | 9:45 A.M. | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| Male | | | White | | | August 21, 1909 | | | 59 | | | MONTHS 3 | | | DAYS 19 | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| Bakersville, Md. | | | U. S. A. | | | | | | Washington Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (Give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| Hagerstown | | | Washington Co. Hospital | | | Operator | | | City Water Dept. | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | Washington | | | Boonsboro | | | Rfd. 2 | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Richard D. Bloom | | | Nannie Mongan | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | | | | | |
| No. | | | 214-09-6430 | | | Mrs. Florence V. Bloom, Rfd. 2, Boonsboro, Md | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction | | | | | | | | | | | | | | | | | 4109 | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis | | | | | | | | | | | | | | | | | Rupture | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Anterior Heart Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | 4201 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/24, 1967, to 10/10, 1968, that (I) (we) lost saw the deceased alive on 10/4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Adney Novenstein M.D. | | | 10-11-68 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIDNEY NOVENSTEIN | | | FUNKSTOWN MD | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | |
| Burial | | | 12-13-68 | | | Boonsboro Cemetery | | | Boonsboro, Wash. Co., Md. | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md | | | DEC 16 1968 | | | Charles Judge | | | | | | | | | | | | | | | | | | | | | | | |

1933

1933

Wilson, Richard, 12, 1900, 1933

Wilson, Richard, 12, 1900, 1933

Wilson, Richard, 12, 1900, 1933

Wilson, Richard, 12, 1900, 1933

Wilson, Richard, 12, 1900, 1933

Wilson, Richard, 12, 1900, 1933

Wilson, Richard, 12, 1900, 1933

Wilson, Richard, 12, 1900, 1933

Wilson, Richard, 12, 1900, 1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 18333 | | | | | | | | | | 18352 | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|---|--|---|--|--|--------------------------------|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | | | |
| First Middle Last Charles Edward Boward | | | | | | | | | | 12 Month 21 Day 68 Year 8:20 P. M. | | | | | | | | | | | | |
| 3. SEX male | | | 4. RACE white | | | 5. DATE OF BIRTH June 9, 1902 | | | 6. AGE (In years last birthday) 66 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Washington Md. | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) sales represent. | | | 12b. KIND OF BUSINESS OR INDUSTRY trucking | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Wash. | | | 13c. CITY OR TOWN Hagerstown | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 844 Guilford Ave. | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last George R. Boward | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Minnie C. Lechrone | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? no Yes, no, or unknown (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. 214-09-0533 | | | | | 17. INFORMANT Mary Jane Boward | | | | | Address Hagerstown, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 403X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month Years | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 446X Diabetes mellitus | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1 Dec</u> , 19 <u>68</u> , to <u>22 Dec</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>22 Dec</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> 4P | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 12/23/68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE 12-24-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home | | | | | | | | | | ADDRESS Hagerstown, Md. | | | 25a. REC'D BY REGISTRAR DEC 27 1968 | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | |

• • • •

822 19330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18340 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18353 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-------------------------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 20. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LUTHER PETER BOWMAN | | | | | | | | | | DECEMBER Month 10 Day 68 Year | | | | | | | | | | 6 a M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years lost birthday) | | | | | | | | | | IF UNDER 1 YEAR | | | | | | | | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MALE | | | | | | | | | | WHITE | | | | | | | | | | JULY 4, 1894 | | | | | | | | | | 74 YRS. | | | | | | | | | | MONTHS | | | | | | | | | | DAYS | | | | | | | | | | HOURS | | | | | | | | | | MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MARYLAND | | | | | | | | | | U.S.A. | | | | | | | | | | | | | | | | | | | | WASHINGTON | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HAGERSTOWN | | | | | | | | | | WASHINGTON COUNTY HOSP. | | | | | | | | | | RETIRED LABOR | | | | | | | | | | RUBBER FACTORY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MARYLAND | | | | | | | | | | WASHINGTON | | | | | | | | | | HAGERSTOWN | | | | | | | | | | YES | | | | | | | | | | 241 1/2 E. FRANKLIN ST. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SCOTT | | | | | | | | | | BOWMAN | | | | | | | | | | AMANDA | | | | | | | | | | MULLENIX | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | 241 1/2 Address | | | | | | | | | | E. FRANKLIN ST. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NO | | | | | | | | | | 220-09-9310 | | | | | | | | | | MRS. BLANCHE BOWMAN | | | | | | | | | | HAGERSTOWN, MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Pneumonia, bilateral</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 491X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) <u>Chronic bronchitis and emphysema</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>63</u> , to <u>12-10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <u>Charles C. Spencer, M.D.</u> | | | | | | | | | | DEGREE | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 12/10/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CHARLES C. SPENCER, M.D. | | | | | | | | | | 145 S PROSPECT ST., HAGERSTOWN, MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BURIAL | | | | | | | | | | 12/12/68 | | | | | | | | | | REST HAVEN CEMETERY | | | | | | | | | | HAGERSTOWN, WASHINGTON, MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <u>Charles M. Rouger</u> | | | | | | | | | | HAGERSTOWN, MARYLAND | | | | | | | | | | DEC 13 1968 | | | | | | | | | | <u>Charles Judge</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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CHURCHMAN IN WASH DC

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18341

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18354

| | | | | |
|---|-----------------------------|---|--|---|
| 1. DECEASED-NAME (Type or print) Annie First Lydia Middle Brägunier Last | | 2a. DATE OF DEATH Month Dec. Day 7 Year 1968 | | 2b. HOUR 8.30 a.m. or p.m. |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH September 23, 1881 | | 6. AGE (In years last birthday) 87 YRS. |
| 7a. BIRTHPLACE (State or foreign country) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Practical nurse. |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.. | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown |
| 14. FATHER'S NAME DANIEL First Mr. RICE Middle Mr. RICE Last | | 15. MOTHER'S MAIDEN NAME-First MARY Middle ELIZABETH Last POTTS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT MRS. LOUISE EASTERDAY HAGERSTOWN Address MD. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4129 IMMEDIATE CAUSE (a) Complete heart block DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 20 years | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4330 Fracture of rt. intertrochanteric. | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 7, 1967 to Dec. 7, 1968 , that (I) (we) last saw the deceased alive on Dec. 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE Chong Choon Han DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED Dec. 7, 1968 |
| 22d. PHYSICIAN'S NAME (Type) Chong Choon Han | | 22e. ADDRESS Western Md. State hosp., Hagerstown, Md.. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE 12/9/68 | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM. | | 23d. LOCATION City or Town County State HAGERSTOWN WASH. MD. |
| 24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md. ADDRESS | | 25a. REC'D BY REGISTRAR DATE DEC 10 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge |

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WASHINGTON

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

OFFICE OF THE SECRETARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARTIN COUNTY DEPARTMENT OF HEALTH | | | | | | | | | | | |
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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| Item #9, Film #G109 1/28/69 km | | | | | | | | | | | |
| 18355 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE West Virginia b. COUNTY Berkeley c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gerrardstown d. STREET ADDRESS Route 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Mamie Catherine Braithwaite | | | | | | 4. DATE OF DEATH Month December Day 30 Year 19 68 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 2, 1896 | | 9. AGE (In years last birthday) 71 7/2 rs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House duties | | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | | | 11. BIRTHPLACE (County & State, or foreign country) Berkeley County, W.Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William T. Hess | | | | | | 14. MOTHER'S MAIDEN NAME Mary C. McDaniel | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Anthony W. Braithwaite | | | | Address Route 1 Gerrardstown, W.Va. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized Metastasis DUE TO (c) Cancer of left lung | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 163x | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | | | | | |
| 2Dc. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 19 | | 2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - | | 20f. (City or town) - | | (County) - | | (State) - | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct. , 19 68 to Dec. , 19 68 , that (I) (we) last saw the deceased alive on December 30, 19 68 , and that death occurred at P.M. , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Harold R. Tritch, Jr | | | | | | M.D. Harold R. Tritch, Jr MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED Jan 2 1969 | |
| 22c. PHYSICIAN'S NAME (Type) Harold R. Tritch, Jr MD | | | | | | 22d. ADDRESS 302 N. Potomac St Hagerstown, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Jan. 2, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY Pleasant View Memory Gardens | | 23d. LOCATION (City, town or county) Martinsburg, W. Va. | | (State) W. Va. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Howard R. Brown | | | | | | ADDRESS Brown Funeral Home-Martinsburg, West Virginia | | 25a. REC'D BY REGISTRAR JAN 6 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

1935

WYOMING STATE DEPARTMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

| 18343 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18356 | |
|---|--|--|------------------------------|--|--|--|--|-------------------|---------------------------------|---|--|------------------------|--|------------------------|--|--|--|--|--|-------|--|
| Items#5&6, FilmG409 1/29/69 km | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | First Middle Last | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | |
| Charles Andrew Brown | | | | | | | | | | December 11 1968 | | | | | M | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | |
| Male | | | White | | | April 3, 1886/1887 | | | 82 1/2 YRS. | | | MONTHS DAYS HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | |
| Carlisle, Penna. | | | USA | | | | | | Washington Md. | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Hagerstown | | | | | Washington Co. Hospital | | | | | Optometrist | | | | | Optometry | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | |
| Maryland | | | | | Washington | | | Hagerstown | | | | | | 802 Forrest Drive | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | |
| Andrew nm Brown | | | | | Anna Margaret Warner | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | | | | | | | | |
| No | | | | | 212-38-9793 | | | | | Mrs. Rose E. Brown 802 Forrest Dr. Hagerstown, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Abdominal carcinomatosis | | | | | | | | | | | | | | | months | | | | | | |
| 1991 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | |
| 1992 | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/10/ 19 68, to 12/11 19 68, that (I) (we) lost saw the deceased alive on 12/11 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | |
| Howard N. Weeks, M. D. | | | | | | | | | | 12/13/68 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | |
| Howard N. Weeks, M. D. | | | | | | | | | | 580 Northern Ave., Hagerstown, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | | | | 12/15/68 | | | | | Rest Haven Cemetery | | | | | Hagerstown-Washington-Md. | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Rest Haven Funeral Chapel | | | | | | | | | | Hagerstown, Md. | | | | | DEC 16 1968 | | | | | | |

10000



James M. [illegible]

12-12-1914
J. M. [illegible]
J. M. [illegible]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 1500 (5)
10M 2271 (5)

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|------------------------------|--|--|------------------|---|-----------------|---|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Mary Edna Brown | | | | | | Dec. 19, 1968 | | 2:30 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD |
| Female | White | June 9, 1915 | | 53 YRS. | MONTHS 6 DAYS 10 | | HOURS MIN. | | December 19, 1968 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U. S. A. | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | | 65 1/2 West Franklin Street | | | Housewife | | Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | | Washington | | | Hagerstown | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e. STREET AND NUMBER | | | |
| George W. Domer | | | Ada N. Kendall | | | 65 1/2 West Franklin Street | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | |
| No | | | | | | Charles E. Garlock 65 1/2 W. Franklin Street, Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion & perforation</u> DUE TO, OR AS A CONSEQUENCE OF <u>heart & hemopericardium</u> (b) <u>4100</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>4201 nephrosclerosis</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 hr med</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| CAUSE OF DEATH | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <u>Edward W. Ditto</u> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <u>12-20-68</u> | | | |
| EXAMINER'S NAME (Type) <u>E.E.W. Ditto, III, M.D.</u> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | ADDRESS (Street, city, town, or county) <u>217 W. Washington St. Hagerstown, Md.</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 12/23/68 | | Boonsboro Cemetery | | Boonsboro, Washington, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| John H. Bast, Jr. 112 N. Main St., Boonsboro, Md. | | | | | | DEC 23 1968 | | <u>Charles Judge</u> | |

John W. Jones, Jr., 112 W. Main St., Hattiesburg, Miss.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|------------------------------|--|--|---|---|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR |
| Mervin Clarence Brown | | | | | | Month Day Year | | | 12 17 1968 |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | 2c. DATE PRONOUNCED DEAD | 2d. HOUR |
| male | white | 1-26-1898 | 70 YRS. | | | | | Month Day Year | 12 17 1968 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| West Virginia | | USA | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | | Wash. County Hospital | | | Assembly | | Aircraft Mfg. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Md. | | | Wash. | | | Hagerstown | | 829 Chestnut, St. | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| William L. Brown | | | Mary E. LeMaster | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| yes | | | WW I | | Mrs. Ruth Brown Hagerstown, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5718 Portal Aneurysm - Marked Ascaris | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) + Hepatic failure with | | | | | | | | | 6-12 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) Bilateral Lobular Pneumonia | | | | | | | | | 48 hrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | 22 hr |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER | | | 12-18-68 | | | |
| Edward W. Ditto, III, M.D. | | | DEPUTY MEDICAL EXAMINER | | | 217 W. Washington St. Hagerstown, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 12-21-68 | | Elmwood Cemetery | | Shepherdstown, W. Virginia | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Minnich Funeral Home Hagerstown, Md. | | | DEC 23 1968 | | | | | | |

1938

WILSON COUNTY, MISSOURI

STATE OF MISSOURI
JULY 1938

WILSON COUNTY, MISSOURI

Male

White 1-20-1893

70

X

WILSON

17-1-1914

WILSON COUNTY, MISSOURI

WILSON COUNTY, MISSOURI

WILSON COUNTY, MISSOURI

WILSON COUNTY, MISSOURI

WILSON COUNTY, MISSOURI

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WILSON COUNTY, MISSOURI

WILSON COUNTY, MISSOURI

Shepherdstown, W. Va.

WILSON COUNTY, MISSOURI

WILSON COUNTY, MISSOURI

WILSON COUNTY, MISSOURI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 18346 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18359 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| EDWARD STUART BUSHONG SR. | | | | | | | | | | DECEMBER Month 22 Day 68 Year | | | | | | | | | | 6:18am | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years lost birthday) | | | | | IF UNDER 1 YEAR | | | | | IF UNDER 24 HRS. | | | | |
| MALE | | | | | WHITE | | | | | JUNE 10, 1904 | | | | | 64 YRS. | | | | | MONTHS | | | | | DAYS | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | Md. | | | | |
| WEST VIRGINIA | | | | | U.S.A. | | | | | | | | | | WASHINGTON | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| HAGERSTOWN | | | | | WASHINGTON COUNTY HOSP. | | | | | LAWYER | | | | | LAW | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| MARYLAND | | | | | WASHINGTON | | | | | BOONSBORO | | | | | | | | | | R.F.D. #1 | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| DANIEL B BUSHONG | | | | | SALLY ROBINSON | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | |
| NO | | | | | 220-34-0182 | | | | | MRS. RACHAEL BUSHONG, BOONSBORO, RFD #1 | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Swallowing food from ruptured varix</i> | | | | | | | | | | | | | | | 3 days | | | | | | | | | | | | | | |
| 5719 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5810 (b) <i>Arteriosclerosis of liver</i> | | | | | | | | | | | | | | | 1 yr. | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Rheumatic heart disease & tubal insufficiency</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April, 1964, to Dec 22, 1968, that (I) (we) last saw the deceased alive on Dec 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | |
| <i>Edson B Moody</i> | | | | | | | | | | | | | | | 12/23/68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) EDSON B MOODY, M.D. | | | | | | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | 363 CLEVELAND AVE., HAGERSTOWN, MD. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| BURIAL | | | | | 12/24/68 | | | | | ST MARK'S CEMETERY | | | | | BOONSBORO, WASHINGTON, RD#1, MD. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| <i>Charles M. Rieger</i> HAGERSTOWN, MARYLAND | | | | | | | | | | | | | | | DEC 30 1968 | | | | | <i>Charles Judge</i> | | | | | | | | | |

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DEC 10 1988

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 13 Film 407
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
12/23/68 kk 18347

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18360

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|------------------|--|--|---|--|--|---|--|--|---|--|--|----------------------------------|--|--|--|--|--|------------|--|--|---|--|--|----------------------------|--|--|
| 1. DECEASED-NAME (Type or Print) | | | First OTIS | | | Middle MC KINLEY | | | Last CAGLE | | | 2a. DATE KNOWN OF ESTI- DEATH MATED | | | Month 12 | | | Day 29 | | | Year 68 | | | 2b. HOUR a M | | | | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH 7-30-22 | | | 6. AGE (in years last birthday) 46 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN | | | 2c. DATE PRONOUNCED DEAD Month 12 | | | Day 9 | | | Year 68 | | | 2d. HOUR 8:30 a M | | |
| 7a. BIRTHPLACE (State or foreign country) North Carolina | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | 9. COUNTY OF DEATH Washington County | | | | | | Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethel Street | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | | | 13b. COUNTY Washington | | | | | | 13c. CITY OR TOWN Hagerstown | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | 13e. STREET AND NUMBER 201 N. Jonathan St. | | | | | |
| 14. FATHER'S NAME First Zoro M. Cagle | | | | | | Middle Last | | | | | | 15. MOTHER'S MAIDEN NAME First Mattie Corchran | | | | | | Middle Last | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | | | | | 16b. SOCIAL SECURITY NO. (If give name and dates of service) WWII | | | | | | 17. INFORMANT ADDRESS William Cagle Hendersonville, N. C. | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure 3032 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF 3221 (c) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic alcoholism, contusion forehead and laceration of scalp. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rear of Bethel St. | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State Behind Ebenezer Church, Hagers. Md. | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Howard N. Weeks, MD. Washington | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | 22b. DATE SIGNED 12/10/68 | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | | | | | 23b. DATE 12 10 68 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Tryon Cemetery | | | | | | 23d. LOCATION (City or Town) (County) (State) Tryon North Carolina | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md. | | | | | | 25a. REC'D BY REGISTRAR DEC 16 1968 | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | |

1938

[Faint, mostly illegible text and markings covering the page, including a large circular stamp on the right side and a small circular mark near the bottom right corner.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 18348 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 18361 | |
| Item 8 Film 408 1/3/69 kk | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | First Walter | | Middle Rodney | | Last Carey | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH 2-28-1901 | | 2a. DATE OF DEATH 12 Month 21 Day 68 Year | |
| 7a. BIRTHPLACE (State or foreign country) Penna. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Wash. | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last John Samuel Carey | | 15. MOTHER'S MAIDEN NAME First Middle Last Sarah E. Gearhart | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes | | 16b. SOCIAL SECURITY NO. WW II 197-09-9582 | | 17. INFORMANT Address Myrtle Cooper Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis (advanced)</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>not known</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>not known</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>002 / Severe Asbestosis</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 12</u> , 19 <u>68</u> , to <u>Dec 21</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 21</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>B.B. Kneisley M.D.</u> | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>Dec. 24, 1968</u> | |
| 22d. PHYSICIAN'S NAME (Type) B.B. KNEISLEY | | 22e. ADDRESS <u>1406 Washington St. Hagerstown Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12-24-68 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. | |
| 24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md. | | 25a. REC'D BY REGISTRAR DEC 27 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 117-14
30M REC'D 1/68

| <div>18349</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>18362</div> | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|------------------------------|-----------------------------------|--|------------------|--|--|
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| Kathryn Percilla Conkling | | | | | | Dec. Month 29 Day 1968 Year | | | 3:50 M | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Female | | White | | ? 1875 | | | 93 YRS. | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | | | |
| New York | | USA | | | | | WASHINGTON | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| HAGERSTOWN | | | WESTERN MD. STATE HOSPITAL | | | Housewife | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | |
| Maryland | | | Washington | | Boonsboro | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Route 2 | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| George Washburn | | | Kathryn | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | |
| No | | | None | | | Western Md. State Hospital Records | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic heart disease</u> 4120 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 yrs | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443X | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Feb. 14, 1963</u> , to <u>Dec. 29, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec. 29, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Fe U. Porciuncula M.D.</u> | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 12/30/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Fe U. Porciuncula, M.D. | | | | | 22e. ADDRESS Western Maryland State Hospital 1500 Pennsylvania Ave., Hagerstown, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | 1- 1- 69 | | Boonsboro Cemetery | | | Boonsboro, Wash. Co., Md. | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | | | | | JAN 6 1969 | | <u>Charles Judge</u> | | | |

333

| Name | Address | City | State | Zip |
|--------------|-----------------|-----------|-------|-------|
| John H. Bart | 112 W. Main St. | Baltimore | Md. | 21201 |
| Bart | 112 W. Main St. | Baltimore | Md. | 21201 |
| Bart | 112 W. Main St. | Baltimore | Md. | 21201 |
| Bart | 112 W. Main St. | Baltimore | Md. | 21201 |
| Bart | 112 W. Main St. | Baltimore | Md. | 21201 |
| Bart | 112 W. Main St. | Baltimore | Md. | 21201 |
| Bart | 112 W. Main St. | Baltimore | Md. | 21201 |
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| Bart | 112 W. Main St. | Baltimore | Md. | 21201 |
| Bart | 112 W. Main St. | Baltimore | Md. | 21201 |
| Bart | 112 W. Main St. | Baltimore | Md. | 21201 |
| Bart | 112 W. Main St. | Baltimore | Md. | 21201 |
| Bart | 112 W. Main St. | Baltimore | Md. | 21201 |
| Bart | 112 W. Main St. | Baltimore | Md. | 21201 |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------|------------------------------|---|---|--------------------------------|--|--|--|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF ESTI- DEATH MATED | | | 2b. HOUR |
| Charles Sylvester Coyle | | | | | | 12-27-1981 | | | P. M. |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| Male | White | May 16, 1920 | 48 YRS. | | | 12-27-88 | | | 5:40 P. M. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Keedysville, Md. | | USA | | | | Washington | | | Md. |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Hagerstown | | | 57 S. Potomac St. (Colonial Hotel) | | | Inspector | | | Aircraft |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| Maryland | | | Washington | | | Hagerstown | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. |
| Sylvester nnn Coyle | | | Florence Anna Rohrer | | | No | | | 214-16-0865 |
| 17. INFORMANT | | | 18. ADDRESS | | | 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? |
| Mrs. Carroll Uhler | | | 1201 Ravenwood Heights, Hagerstown, Md. | | | 5810 | | | |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of vomitus DUE TO, OR AS A CONSEQUENCE OF Multiple hematomas and bruises (b) (old and recent) left eye, left shoulder, left forearm & elbow, left & right back, right hip & right leg. Fatty metamorphosis of liver, marked. (c) leg. Fatty metamorphosis of liver, marked. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few minutes Recent |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER | | | 12-28-68 | | | |
| DR. E. W. DITTO, JR. | | | 215 W. Washington St., Hagerstown, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 12/30/68 | | Mountain View Cemetery | | Sharpsburg-Washington-Md. | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Rest Haven Funeral Chapel | | | Hagerstown, Md. | | | DEC 31 1968 | | | Charles Judge |

2303

214-16-682

APR 1 1968

W.C. West

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| 1. DECEASED-NAME (Type or Print) | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
|--|--------|--------------------|--|---------------------------|----------|--|--------------------------|---|---|-----------------------------------|--|----------|--|
| First | Middle | Last | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | | |
| BLANCHE EDNA CRAWFORD | | | Dec 18 1968 | | 3:45 PM | | Dec 18 1968 | | 4:15 PM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | | |
| Female | | White | | July 20, 1893 | | 75 YRS | | Maryland | | U.S.A. | | | |
| 8. MARRIED | | 9. COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| WIDOWED | | Washington | | Hagers town | | 545 Maryland Ave | | Housewife | | Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | |
| Maryland | | Washington | | Hagers town | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 545 Maryland Ave | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | | |
| James J. Miller | | | Laura V. Crilley | | | no | | | 217-32-7303 | | | | |
| 17. INFORMANT | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | |
| John E. Crawford, 16 Avalon Ave | | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4109 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. 4201 (b) Coronary atherosclerosis and (c) Advanced gen/ arteriosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Recent viral gastro-intestinal | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Turned 20 yrs? 20 yrs? | | | | |
| 20. AUTOPSY? | | | 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | CAUSE OF DEATH | | | HOUR A.M. P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town County State | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | 22b. DATE SIGNED | | | 23a. REC'D BY REGISTRAR | | | 23b. REGISTRAR'S SIGNATURE | | | | |
| ACTUAL SIGNATURE Edward W. Ditto, III, M.D. | | | 12-19-68 | | | DEC 26 1968 | | | Charles Judge | | | | |
| EXAMINER'S NAME (Type) | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or town) (County) (State) | | | | | | | |
| Burial | | | Rest Haven Cemetery | | | Hagerstown, Md. | | | | | | | |
| 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or town) (County) (State) | | | | | | | |
| 12/21/68 | | | Hagers town, Md. | | | Hagerstown, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Andrew K. Coffman Funeral Home, Inc | | | DEC 26 1968 | | | Charles Judge | | | | | | | |

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 11/11/2019 10:11:11 AM

James L. Telle
David V. Little

James K. Coffman Funeral Home, Inc.
Hagers town, Md.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 18352 | | | | | | | | | | 18365 | | | | | | | | | | | | | |
|--|--|-------------------------|--|---|--|---|--|---|--|---|--|--|--|---|-----------------------------|---|--------------------------------|---|--|--|--|--|--|
| MAYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) Albert Nihiser Davis | | | | | | | | | | 2a. DATE KNOWN OF ESTI- DEATH MATED Dec. 1, 68 | | | | | 2b. HOUR 10 P. M. | | | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH Sept. 13/13 | | 6. AGE (In years last birthday) 55 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD Month December Day 1 Year 1968 | | | | | 2d. HOUR 12:40 P. M. | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Washington | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH Washington | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 26 1/2 East Franklin St. Labor | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Water Dept | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY Water Dept | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | | | | | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 26 1/2 East Franklin St. | | | | | | | |
| 14. FATHER'S NAME First Middle Last Charles W. Davis | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Carrie M. Norris | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16b. SOCIAL SECURITY NO. (If no, give number of service) W.W.#2 214-09-5298 | | | | 17. INFORMANT ADDRESS Mrs Viola M. Burger Havre De Grace Md. Box 206 | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4339 IMMEDIATE CAUSE (a) Thrombosis of both middle cerebral arteries DUE TO, OR AS A CONSEQUENCE OF (b) Calcific aortic stenosis, severe DUE TO, OR AS A CONSEQUENCE OF (c) Possible active endocarditis of aortic valve with | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Recent | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 332X embolization. | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Dr. E.W. Ditto, Jr. | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| EXAMINER'S NAME (Type) Dr. E.W. Ditto, Jr. | | | | | | | | | | 22b. DATE SIGNED 12-4-68 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE Dec. 4, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Hagerstown, Md. Andrew K. Coffman Funeral Home Inc. | | | | | | | | | | 25a. REC'D BY REGISTRAR DEC 6 1968 | | | | | | | | | | | | | |
| | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE f Charles Judge | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 18353 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18366 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 20. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Margaret Viola Daener | | | | | | | | | | Dec Month 22 Day 1968 | | | | | | | | | | 5:55PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX Female | | | | | | | | | | 4. RACE White | | | | | | | | | | 5. DATE OF BIRTH 4-12-1894 | | | | | | | | | | 6. AGE (In years last birthday) 74 YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH WASHINGTON Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | | | | | | | 13b. COUNTY Washington | | | | | | | | | | 13c. CITY OR TOWN Boonsboro | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER Route 1, Boonsboro Md. | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last Samuel HINES | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last ANNIE PIERCE | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. 219-34-7446 | | | | | | | | | | 17. INFORMANT Joseph Daener Address Same | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4340 DUE TO, OR AS A CONSEQUENCE OF (b) Bronchopneumonia (c) Cerebral Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332x | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 5 1/2 months | | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized atherosclerosis; nephrosclerosis; Chronic pyelonephritis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-30, 1968, to 12-22, 1968, that (I) (we) lost the deceased alive on 12-22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE Edmund Riley M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED DEC 23, 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Edwin G. Riley | | | | | | | | | | 22e. ADDRESS Western Md. State Hospital | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE Dec. 26, 1968 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Brownsville Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) Brownsville Wash. Md. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St, Boonsboro, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 30 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

14363

RECEIVED

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Magaret Hold. Turner Dec 22 1968

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Charm B. Green
Edwin G. Riley

DEC 19 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A-15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|--|--|--|-------------------|---|--|--|-----------------------------------|---|--|------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| Grace | | Carrie | | Diehl | | | | 12 Month 29 Day 68 Year | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| male | | white | | Nov. 13, 1894 | | | 74 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Penna. | | USA | | | | Washington Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Williamsport | | | Williamsport Sanitarium | | | housewife | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | | Wash. | | Funkstown | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 41 E. Baltimore St. | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | | First Middle Last | | | | | | | | |
| Harvey Senger | | | | Barbara Petre | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | |
| no | | | | no | | Mrs. Mildred Beckley Funkstown, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cachexia | | | | | | | | | | | | |
| 4379 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | |
| (b) advanced senility | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) Cerebral arteriosclerosis | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | |
| 334x | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| none | | 0 | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| | | HOUR A.M. Month Day Year | | none | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | | |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | none | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug '61, 19, to Dec 29, 19 68, that (I) (we) last saw the deceased alive on Dec 12, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED |
| Harold R. Tritch, Jr MD | | | | | | | | | | | | 12/30/68 |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | | | |
| Harold R. Tritch, Jr MD | | | | 302 N. Potomac St Hagerstown, Md | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | |
| Burial | | 12-31-68 | | Rest Haven Cemetery | | Hagerstown, Md. | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Minnich Funeral Home Hagerstown, Md. | | | | | | DATE JAN 3 1969 | | Charles Judge | | | | |

| Name | Address | City | State | Zip |
|------------------|-----------------|-----------------|-------|-------|
| Mr. J. H. Smith | 123 Main St. | New York | NY | 10001 |
| Mrs. A. B. Jones | 456 Elm St. | Los Angeles | CA | 90001 |
| Mr. C. D. Brown | 789 Oak St. | Chicago | IL | 60601 |
| Mr. E. F. Green | 321 Pine St. | Houston | TX | 77001 |
| Mr. G. H. White | 654 Maple St. | Phoenix | AZ | 85001 |
| Mr. I. J. Black | 987 Cedar St. | San Francisco | CA | 94101 |
| Mr. K. L. Gray | 210 Birch St. | Portland | OR | 97201 |
| Mr. M. N. Hall | 543 Spruce St. | Seattle | WA | 98101 |
| Mr. O. P. Young | 876 Ash St. | Denver | CO | 80201 |
| Mr. Q. R. King | 109 Willow St. | San Diego | CA | 92101 |
| Mr. R. S. Lee | 432 Hickory St. | Dallas | TX | 75201 |
| Mr. T. U. Scott | 765 Walnut St. | San Jose | CA | 95101 |
| Mr. V. W. Adams | 098 Cherry St. | Austin | TX | 78701 |
| Mr. X. Y. Baker | 321 Elm St. | Fort Worth | TX | 76101 |
| Mr. Z. A. Carter | 654 Oak St. | Memphis | TN | 38101 |
| Mr. B. C. Evans | 987 Pine St. | Nashville | TN | 37201 |
| Mr. D. E. Fisher | 210 Cedar St. | Jacksonville | FL | 32201 |
| Mr. F. G. Hill | 543 Birch St. | Tampa | FL | 33601 |
| Mr. H. I. Jones | 876 Spruce St. | Orlando | FL | 32801 |
| Mr. J. K. King | 109 Ash St. | Fort Lauderdale | FL | 33301 |
| Mr. L. M. Lee | 432 Willow St. | Miami | FL | 33101 |
| Mr. N. O. Scott | 765 Cherry St. | Hialeah | FL | 33151 |
| Mr. P. Q. Adams | 098 Elm St. | Coral Gables | FL | 33134 |
| Mr. R. S. Baker | 321 Oak St. | West Palm Beach | FL | 33411 |
| Mr. T. U. Carter | 654 Pine St. | Boca Raton | FL | 33433 |
| Mr. V. W. Evans | 987 Cedar St. | Delray Beach | FL | 33484 |
| Mr. X. Y. Fisher | 210 Birch St. | Fort Myers | FL | 33901 |
| Mr. Z. A. Hill | 543 Spruce St. | Sarasota | FL | 34237 |
| Mr. B. C. Jones | 876 Ash St. | Bradenton | FL | 34208 |
| Mr. D. E. King | 109 Willow St. | Palmdale | CA | 93550 |
| Mr. F. G. Lee | 432 Cherry St. | Tulare | CA | 93234 |
| Mr. H. I. Scott | 765 Elm St. | Visalia | CA | 93251 |
| Mr. J. K. Adams | 098 Oak St. | Hanford | CA | 93230 |
| Mr. L. M. Baker | 321 Pine St. | Corcoran | CA | 93226 |
| Mr. N. O. Carter | 654 Cedar St. | Wasco | CA | 93280 |
| Mr. P. Q. Evans | 987 Birch St. | Arvin | CA | 93203 |
| Mr. R. S. Fisher | 210 Spruce St. | Lemoore | CA | 93245 |
| Mr. T. U. Hill | 543 Ash St. | Reedley | CA | 93254 |
| Mr. V. W. Jones | 876 Willow St. | Manteca | CA | 95230 |
| Mr. X. Y. King | 109 Cherry St. | Camarillo | CA | 93601 |
| Mr. Z. A. Lee | 432 Elm St. | Santa Maria | CA | 93455 |
| Mr. B. C. Scott | 765 Oak St. | Santa Barbara | CA | 93101 |
| Mr. D. E. Adams | 098 Pine St. | Goleta | CA | 93021 |
| Mr. F. G. Baker | 321 Cedar St. | Paso Robles | CA | 93426 |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 18355 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|----------------------------|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) First Middle Last HAZEL JOY EBY | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED Month Day Year 12 22 1968 | | | 2b. HOUR 3:30 AM | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH 11/23/68 | | 6. AGE (in years last birthday) YRS. MONTHS DAYS — 29 | | IF UNDER 1 YEAR MONTHS DAYS — 29 | | IF UNDER 24 HRS HOURS MIN — | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON | | | | | |
| 10. CITY OR TOWN OF DEATH HAG. RD 4 | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RD 4 - Hagerstown | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE | | 12b. KIND OF BUSINESS OR INDUSTRY NONE | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | | 13b. COUNTY WASH. | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER RD 4 - Hagerstown | |
| 14. FATHER'S NAME First Middle Last Nelson EBY | | | | 15. MOTHER'S MAIDEN NAME First Middle Last DORIS MILLER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16b. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Nelson Eby - Hagerstown Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUFFOCATION DUE TO STEAM KETTLE DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE BRONCHITIS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 466X | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SHORT INTERVAL SEVERAL DAYS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 500X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE J. W. Ditto M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) DR. E.W.DITTO, JR. | | | | | | ADDRESS (Street, city, town, or county) | | 22b. DATE SIGNED 12-22-68 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 12/24/68 | | 23c. NAME OF CEMETERY OR CREMATORY Keith Ch. Cem. | | 23d. LOCATION (City or Town) (County) (State) WASH. Co., Md. | | | | | |
| 24. FUNERAL DIRECTOR A.G. Minnich - Greencastle, Pa. | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DEC 26 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

STATE
HEALTH DEPT.



ACUTE BRONCHITIS
SUFFOCATION DUE TO STEAM KETTLE

SEVERAL CA
INTERVAL
SHORT

DR. F. W. DITTO, JR.

X

X

X

12-22-08

DEC 22 1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|------------------------------|--|--|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 18356 | | | | | 18369 | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| STERLING WALLACE EDWARDS | | | | | December 17 1968 | | | 2.30 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| male | | white | | Oct. 3, 1900 | | | 68 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Balto. Co. Md. | | U.S.A. | | | | Washington Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | | Washington Co. Hospital | | | Retired Teacher | | | Public Sch. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Frederick | | Myersville | | | | Route # 2 | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| Sterling W. Edwards | | | | | Delia Ennals Edwards | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | Address | | |
| yes | | | W W # 1 | | Mrs. Ellen W. Edwards | | | Rt. #2 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Hemorrhage | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Metastatic Brain | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Malignant Melanoma Back | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| Hypertension | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12 Dec, 19 68, to 17 Dec, 19 68, that (I) (we) last saw the deceased alive on 17 Dec 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | 22c. DATE SIGNED | | |
| Frank E. Brumback MD | | | | | | | | 18 Dec 68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | 22e. ADDRESS | | |
| 117 King St | | | | | | | | Hagerstown, Md | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Dec. 19, 1968 | | Mt. Olivet | | | Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Paul F. Bittle, Myersville, Md | | | | | | DEC 23 1968 | | Charles Judge | | |

93581

UNITED STATES DEPARTMENT OF AGRICULTURE



OFFICE OF THE
DIRECTOR OF AGRICULTURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|----------------------|--|----------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 18370 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| GLENN ERDMAN EYLER | | | | | | DECEMBER 22 1968 | | 10A | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| MALE | | WHITE | | 1/3/1903 | | 65 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| PENNSYLVANIA | | U.S.A. | | | | WASHINGTON | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | Md. | |
| HAGERSTOWN | | WASHINGTON CO. HOSPITAL | | TOOL MAKER | | AIRCRAFT | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | WASHINGTON | | HAGERSTOWN | | | | 125 N. PROSPECT ST. | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| EDWARD EYLER | | | ELBA GRACE MINER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| NO | | | 212-10-0932 | | MISS ELAINE M. EYLER | | HAGERSTOWN MD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Angiostenic Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>5</u> <u>days</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4341</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | 700 68 22 Ave 19 68 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7:00</u> , 19 <u>68</u> , to <u>22:00</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>22 Dec</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>J. D. Wilson</u> M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED <u>12/23/68</u> | |
| 22d. PHYSICIAN'S NAME (Type) <u>DR. J. D. WILSON</u> | | | | | | | | 22e. ADDRESS <u>NORTHERN AVE. HAGERSTOWN, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 12/24/68 | | REST HAVEN CEM. | | HAGERSTOWN WASH. MD. | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>W. J. Norman, Hagerstown, Md.</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>DEC 30 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18358 | | MARYLAND STATE DEPARTMENT OF HEALTH | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 18371 | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | First Middle Last | | 2a. DATE OF DEATH | |
| Jerome Vincent Faith | | | | | | Dec. Month 22 Day 68 Year | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | |
| male | | white | | Oct. 3, 1889 | | 79 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Md. | | USA | | | | Washingt. Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | Wash. Co. Hospital | | maintenance | | aircraft | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Md. | | Wash. | | Hagerstown | | 223 Frederick St. | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | |
| Lewis Faith | | | | Alice M. Sagle | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| yes | | 217-12-1333 | | Leah M. Faith Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Trombosis & Embolism</i> 1519 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Malignancy of Stomach</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Not known</i> 151X | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic Cardiovascular Disease</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 3, 1967</i> to <i>12/22, 1968</i> , that (I) (we) last saw the deceased alive on <i>12/21, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Arthur Riego</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>12-23-68</i> | |
| 22d. PHYSICIAN'S NAME (Type) <i>ARTHUR RIEGO</i> | | | | 22e. ADDRESS <i>119 E. Antietam St.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| burial | | 12-24-68 | | Rest Haven Cemetery | | Hagerstown, Md. | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Minnich Funeral Home Hagerstown, Md. | | | | DEC 27 1968 | | <i>Charles Judge</i> | |

1971

UNITED STATES OF AMERICA

Department of State

Office of the Secretary

Washington, D.C. 20520

January 1, 1971

Dear Sir:

Very

Thank you for your letter of December 15, 1970.

Sincerely,

John F. Kennedy

Enclosure

Very

Respectfully,

John F. Kennedy

Enclosure

Very

Respectfully,

John F. Kennedy

1971

UNITED STATES OF AMERICA

12 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
18359
18372
CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Franklin | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greencastle, Pa. | |
| c. LENGTH OF STAY IN 1b 1 day | | d. STREET ADDRESS 14 Center Square | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Harry Edward Finafrock | | 4. DATE OF DEATH Dec. 7, 1968 | |
| 5. SEX M | | 6. COLOR OR RACE W | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 3, 1914 | |
| 9. AGE (in years last birthday) 54 yrs. | | 10. FINDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10b. KIND OF BUSINESS OR INDUSTRY Commercial Hauling | |
| 11. BIRTHPLACE (County & State, or foreign country) Greencastle, Pa. | | 12. CITIZEN OF WHAT COUNTRY? America, North | |
| 13. FATHER'S NAME Frank B. Finafrock | | 14. MOTHER'S MAIDEN NAME Bertha E. Dale | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 164-16-5146 | |
| 17. INFORMANT Medical Record | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intra-abdominal hemorrhage 4410 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 451X (b) Rupture, abdominal aortic aneurysm DUE TO (c) Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 12 hours 24 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary tuberculosis, bilaterally active | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 6, 1968 to Dec. 7, 1968 , that (I) (we) last saw the deceased alive on Dec. 7, 1968 , and that death occurred at 6:40 AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE J. H. Kehne | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) J. H. KEHNE, M. D. | | 22d. ADDRESS 1229 Ravenwood Hts. Hagerstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/10/1968 | |
| 23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Gardens | | 23d. LOCATION (City, town or county) (State) Chambersburg, Franklin Pa. | |
| 24. FUNERAL DIRECTOR Harold H. Zimmerman | | 25a. REC'D BY REGISTRAR DEC 10 1968 | |
| ADDRESS Greencastle, Pa. | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>183700</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>18373</div> | | | | | | | | | | | |
|---|--|---------|---|------------------|-------------------|---|---|--|---|--|-------------------------------|
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Charles Martin Freed | | | | | | Month Day Year December 31, 1968 | | | 1:55 p.m. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN |
| male | | white | | 1-21-1907 | | | 81 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Maryland | | | USA | | | | | | Washington Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | | Wash. County Hospital | | | truck driver | | | Farmers Cooperative | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Md. | | | Wash. | | Hagerstown | | | | 129 Harp Road | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Arthur N. Freed | | | Jennie F. Rudisill | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| no | | | 217-32-5474 | | | Mrs. Virginia Freed Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF, Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF, Heart Disease (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15-20 min | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | 5-21 1968 to 12-31 1968 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 28 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE E. R. Lardisack | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 1-3-68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | |
| E. R. Lardisack | | | 301 W. Preston Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or town) (County) (State) | | |
| burial | | | 1-3-1969 | | | Rest Haven Cemetery | | | Hagerstown, Md. | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Minnich Funeral Home | | | Hagerstown, Md. | | | JAN 6 1969 | | | Charles Judge | | |

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UNITED STATES

December 17, 1952

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male

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Washington

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UNITED STATES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18361 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18374 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | 3-59 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mallie Elizabeth Funk | | | | | | | | | | December 22 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | | IF UNDER 1 YEAR | | | | | | | | | | IF UNDER 24 HRS. | | | | | | | | | |
| Female | | | | | | | | | | White | | | | | | | | | | May 30, 1882 | | | | | | | | | | 86 YRS. | | | | | | | | | | MONTHS DAYS HOURS MIN. | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| Spring Valley, Va. | | | | | | | | | | USA | | | | | | | | | | | | | | | | | | | | Washington | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hagerstown | | | | | | | | | | Washington Co. Hospital | | | | | | | | | | Housewife | | | | | | | | | | Own Home | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. CITY OR TOWN | | | | | | | | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | Washington | | | | | | | | | | Hagerstown | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 730 Summit Ave. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fielden Vaughn | | | | | | | | | | Zilpha Ellen Anderson | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | 215-26-811491 | | | | | | | | | | Mrs. O. B. Funk 415 Guilford Ave. Hagerstown, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5400 Ruptured Appendix | | | | | | | | | | 16 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5501 | | | | | | | | | | (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Arteriosclerotic Heart Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/6, 1968, to 12/22, 1968, that (I) (we) last saw the deceased alive on 12/21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| George Jennings | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 12/23/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| George Jennings | | | | | | | | | | 318 N. Potomac St. Hagerstown, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | 12/24/68 | | | | | | | | | | Rest Haven Cemetery | | | | | | | | | | Hagerstown-Washington-Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rest Haven Funeral Chapel | | | | | | | | | | Hagerstown, Md. | | | | | | | | | | DATE DEC 27 1968 | | | | | | | | | | Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)
30M REV. 7/68

| 18375 | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) MARGARET P. Mary GILFORD | | | | 2a. DATE OF DEATH Month December Day 2 Year 1968 | | | | 2b. HOUR A 2:30 | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Oct. 2, 1909 | | 6. AGE (In years last birthday) 59 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN 0 | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Avalon Manor | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY Hotel | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 544 Chestnut St. | | | |
| 14. FATHER'S NAME First Joseph Middle -- Last Conway | | | | 15. MOTHER'S MAIDEN NAME First Florence Middle -- Last McKenzie | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 216-22-5422 | | 17. INFORMANT William P. Gilford Address 544 Chestnut St. Hagerstown Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Convulsion. DUE TO, OR AS A CONSEQUENCE OF (c) 431.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-2 , 19 68 , to 10-2 , 19 68 , that (I) (we) last saw the deceased alive on 10-2 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Charles C. Spencer | | | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 12-2-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Charles C. Spencer, M.D. | | | | 22e. ADDRESS 145 S. Prospect St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12/4/68 | | 23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery | | 23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md. | | | | | |
| 24. FUNERAL DIRECTOR H. Wayne George | | | | ADDRESS Cumberland, Maryland | | 25a. RECEIVED BY REGISTRAR DATE DEC 6 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18363 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18376 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| John David Grimsley | | | | | | | | | | Dec Month 23 Day 1968 Year | | | | | | | | | | 8:55 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX Male | | | | | | | | | | 4. RACE White | | | | | | | | | | 5. DATE OF BIRTH 3/8/90 | | | | | | | | | | 6. AGE (In years last birthday) 78 YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Va | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH WASHINGTON | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED STOCKMAN | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY MACHINE MFG. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md | | | | | | | | | | 13b. COUNTY Wash | | | | | | | | | | 13c. CITY OR TOWN Hagerstown | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER 1207 Glenwood Ave | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last John Butler Grimsley | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last MARY Lee | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | | | | | | | | | 16b. SOCIAL SECURITY NO. 214-09-3818A | | | | | | | | | | 17. INFORMANT HAROLD E. Grimsley | | | | | | | | | | Address Hagerstown Md 1207 Glenwood Ave 21740 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Lobular pneumonia | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3d years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4500 Diabetes mellitus | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-21, 1967, to 12-23, 1968, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Edwin G. Riley MD | | | | | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 12-23-68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Edwin G. Riley MD | | | | | | | | | | 22e. ADDRESS 1500 Penna, Hagerstown, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE 12/27/68 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) Hagerstown (County) Wash. (State) Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Charles M. Lougher | | | | | | | | | | ADDRESS 305 N. Potomac St. | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 30 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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John David Grimsley
 Male 3/9/10
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Mr. West 17-23-18
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Edwin G. Riley MD 1100 Pennsylvania St
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---|---|---|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last Elmer Glen Gunderman | | | 2a. DATE OF DEATH Month Day Year December 13, 1968 | | 2b. HOUR 10:50 A.M. | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH 11-30-1890 | | 6. AGE (In years last birthday) 78 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. County Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Accountant | | 12b. KIND OF BUSINESS OR INDUSTRY Fruit Growers | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Wash. | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 228 Mealey Pkwy | |
| 14. FATHER'S NAME First Middle Last George Gunderman | | | 15. MOTHER'S MAIDEN NAME First Middle Last Margaret Voelkel | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no | | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 209-03-8024A | | 17. INFORMANT Address Mrs. Mary Gunderman Hagerstown, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemorrhage from esophageal varices 571.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 581.0 (b) Cirrhosis of liver DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Arteriosclerotic cardiac disease - Nephrosclerosis | | | | | | | | | |
| 19a. DATE OF OPERATION 12/8/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Upper GI. hemorrhage | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from 12/8, 1968, to 12/13, 1968, that (I) (we) last saw the deceased alive on 12/13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Omar D. Sprecher, Jr. M.D. | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 12/14/68 | | |
| 22d. PHYSICIAN'S NAME (Type) OMAR D. SPRECHER, Jr. | | | | | 22e. ADDRESS 1229 Ravenwood Hgts. Hagerstown, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12-16-68 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. | | | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md. | | | | | 25a. REC'D BY REGISTRAR DATE DEC 16 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

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12/8/88 Upper GI Hemorrhage X
Hemorrhagic Esophagitis - Hypertension

OHAR D. SPEECHER, JR. 1234 KENNEDY BLVD, HOUSTON, TX 77002
12/14/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| 18365 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18378 | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|------------|--|--|--|--|---------------------|--|--|--|--|
| Item 6 Film 408 1/8/69 kk | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | First KATHERINE | | | | | Middle SMITH | | | | | Last HAGER | | | | | 2a. DATE OF DEATH Month DECEMBER | | | | | Day 26 | | | | | Year 68 | | | | | 2b. HOUR 8:15p M | | | | |
| 3. SEX FEMALE | | | | | 4. RACE WHITE | | | | | 5. DATE OF BIRTH JULY 21, 1881 | | | | | 6. AGE (In years last birthday) 86 87 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH WASHINGTON Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) JACKSON CONV. HOME | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOMEMAKER | | | | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | | | 13b. COUNTY WASHINGTON | | | | | 13c. CITY OR TOWN HAGERSTOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER 9 N. POTOMAC ST. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First JOHN | | | | | Middle OSCAR | | | | | Last SMITH | | | | | 15. MOTHER'S MAIDEN NAME First SARAH | | | | | Middle C | | | | | Last WALTER | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO | | | | | (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT MRS. J WM. GARVER | | | | | 9 Address N. POTOMAC ST. HAGERSTOWN, MARYLAND | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> 450X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 465X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>3/22/54</u> , 19 <u>54</u> , to <u>12/26</u> , 19 <u>68</u> , that (I) <u>did</u> last saw the deceased alive on <u>10/17</u> , 19 <u>68</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Howard N Weeks</u> | | | | | | | | | | | | | | | DEGREE ATTENDING <input checked="" type="checkbox"/> MED. <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR PHYS. PHYS. | | | | | 22c. DATE SIGNED 12/27/68 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) HOWARD N WEEKS, M.D. | | | | | | | | | | | | | | | 22e. ADDRESS 580 NORTHERN AVE., HAGERSTOWN, MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | | 23b. DATE 12/30/68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY | | | | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASHINGTON, MD. | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Charles M. Rausen</u> | | | | | | | | | | | | | | | ADDRESS HAGERSTOWN, MARYLAND | | | | | 25a. REC'D BY REGISTRAR DATE JAN 2 1969 | | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18366

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18379

| | | | | | | | | | | | | | | | | | |
|---|--|----------------------|------------------|---|--|--|--|---|-------------------|---|--|---|--|---|--------------------------|--|--|
| 1. DECEASED-NAME (Type or Print) Orpah | | | First Ann | | | Middle 2 | | | Last Hague | | | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month 12 Day 20 Year 1968 | | | 2b. HOUR 12:40 PM | | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH 4-19-1883 | | 6. AGE (In years last birthday) 85 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN. 0 | | 2c. DATE PRONOUNCED DEAD Month 12 Day 20 Year 1968 | | | 2d. HOUR 12:40 PM | | |
| 7a. BIRTHPLACE (State or foreign country) Pennsylvania | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. County Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | | 13b. COUNTY Wash. | | | | 13c. CITY OR TOWN Hagerstown | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 1630 Dual Hwy | | | |
| 14. FATHER'S NAME First Benjamin Middle Brown | | | | | | 15. MOTHER'S MAIDEN NAME First Anna Middle Gans Last | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | | | 16b. SOCIAL SECURITY NO. None | | | | | | 17. INFORMANT ADDRESS Mrs. Imogene Romesburg Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of Gastric Contents 4109 DUE TO, OR AS A CONSEQUENCE OF Secondary to: (b) Myocardial Infarction + Fracture DUE TO, OR AS A CONSEQUENCE OF (c) at home Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Less 1 hr. 2-4 days 6 days | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 9:00 P.M. Dec 15 19, 1968 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.) Fell at home | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State 1630 Dual Hwy Hagerstown Wash Md | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Edward W. Ditto, III, M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | 22b. DATE SIGNED 12-20-68 | | | | | |
| EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D. | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | 217 W. Washington St. Hagerstown, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE 12-20-68 | | | | 23c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery | | | | 23d. LOCATION (City or Town) (County) (State) Smithfield, Penna. | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md. | | | | | | 25a. REC'D BY REGISTRAR DEC 23 1968 | | | | 25b. REGISTRAR'S SIGNATURE f Charles J. J... | | | | | | | |

10872

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18387 | | | | | | | | | | 18380 | | | | | | | | | |
|--|--|--|---|--|---|---|--|--|---|--|--|---|--|-------------------------------------|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last Glenn A. Hartman | | | | | 2a. DATE OF DEATH Month Day Year Dec 16 1968 | | | | | 2b. HOUR 6 A. M. | | | | | | | | | |
| 3. SEX male | | | 4. RACE white | | | 5. DATE OF BIRTH 4/30/09 | | | 6. AGE (In years last birthday) 59 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Waynesboro Pa. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Washington Md. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist | | | 12b. KIND OF BUSINESS OR INDUSTRY Glideline Co. | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna. | | | 13b. COUNTY Franklin | | | 13c. CITY OR TOWN Rouzeville | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | |
| 14. FATHER'S NAME First Middle Last Harry D. Fisher | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Cora Hershey | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No | | | 16b. SOCIAL SECURITY NO. 195-16-2878 | | | 17. INFORMANT Address Mrs. B. Irene Hartman, Rouzeville Pa. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung (Bronchogenic) 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1621 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-12 , 19 68 , to 12-16 , 19 68 , that (I) (we) last saw the deceased alive on 12-16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Dalton M. Welty, M.D. | | | | | | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 12/17/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D. | | | | | | | | | | 22e. ADDRESS 998 Potomac Ave. Hagerstown, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 12/18/68 | | | 23c. NAME OF CEMETERY OR CREMATORY Harbaugh's | | | 23d. LOCATION (City or Town) (County) (State) Franklin Pa. | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS David Z. Grove, Waynesboro Pa. | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 23 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18388 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18381 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | HOURS MIN. | | | | | | | | | |
| JOHN LEROY HARTZELL | | | | | | | | | | DECEMBER 8 68 | | | | | | | | | | 1:15pm | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | | | IF UNDER 1 YEAR | | | | | IF UNDER 24 HRS. | | | | |
| MALE | | | | | WHITE | | | | | JANUARY 15, 1891 | | | | | 77 YRS. | | | | | MONTHS DAYS HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | |
| ILLINOIS | | | | | U.S.A. | | | | | | | | | | WASHINGTON Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| HAGERSTOWN | | | | | JACKSON CONV. HOME | | | | | RETIRED SUPT. OF STORES | | | | | W.M.R.R. | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| MARYLAND | | | | | WASHINGTON | | | | | HAGERSTOWN | | | | | X | | | | | 811 FORREST DRIVE | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| JOHN MILTON HARTZELL | | | | | MARGARET O'BRIEN HARTZELL | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | | | | | | | | | | | | | | | |
| NO | | | | | 705-10-5674 | | | | | MRS. MARIE HARTZELL 811 Address FORREST DRIVE HAGERSTOWN, MARYLAND | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> | | | | | | | | | | | | | | | 2 day's | | | | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | 3 years | | | | | | | | | | | | | | |
| (b) <u>Cerebral arterio sclerosis</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) <u>Arterio sclerotic cardio vascular disease</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4221 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-1-67</u> , 19 <u> </u> , to <u>12-8-68</u> , 19 <u> </u> , that (I) <u>(we)</u> lost the deceased alive on <u>12-8-68</u> , 19 <u> </u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>E. W. DITTO, JR.</u> | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED <u>12/9/68</u> | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>E. W. DITTO, JR., M.D.</u> | | | | | | | | | | 22e. ADDRESS <u>215 W WASHINGTON ST., HAGERSTOWN, MD.</u> | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| BURIAL | | | | | 12/11/68 | | | | | ROSE HILL CEMETERY | | | | | HAGERSTOWN, WASHINGTON, MD. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Charles M. Reuser</u> | | | | | | | | | | ADDRESS <u>HAGERSTOWN, MARYLAND</u> | | | | | 25a. REC'D BY REGISTRAR <u>DEC 13 1968</u> | | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 18369 CERTIFICATE OF DEATH Dec. 22, 1968 11:30 A.M. 18382 | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last EARL SAMUEL HOLLINGER | | | DATE OF DEATH Month 22 Day 1968 | | 2b. HOUR 11:31 AM | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH JULY 30, 1896 | | 6. AGE (In years last birthday) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY? U. S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON COUNTY Md. | | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY Building Contractor | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | | 13b. COUNTY WASH. | | 13c. CITY OR TOWN HAGERSTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 2377 PA. AVE. | |
| 14. FATHER'S NAME First Middle Last Samuel B. Hollinger | | | 15. MOTHER'S MAIDEN NAME First Middle Last Alice V. Sanders | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no | | | 16b. SOCIAL SECURITY NO. 217 01 8432 | | 17. INFORMANT A. Arabel Hollinger 2377 Pa. Ave. Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u> (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>unknown</u> | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (we) saw the deceased on <u>5-20-66</u> , 19 <u>66</u> , to <u>12-22-68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-22</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>E. R. Landry</u> | | 22c. DATE SIGNED <u>12-22-68</u> | | 22d. PHYSICIAN'S NAME (Type) <u>E. R. Landry</u> | | | | | | |
| 22e. ADDRESS <u>200 W. POTOMAC, HAGERSTOWN, MD</u> | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12/26/68 | | 23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery | | 23d. LOCATION (City or Town) (County) (State) Chestertown, Md. | | | | |
| 24. FUNERAL DIRECTOR <u>J. Wells Wells</u> | | ADDRESS Chestertown, Md. | | 25a. REC'D BY REGISTRAR DATE DEC 30 1968 | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | | |

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FOR STATE HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | |
|---|--|---|--|--|
| 1. DECEASED-NAME (Type or Print) Frederick Robert Hollingsworth | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 12 Day 11 Year 1968 | | 2b. HOUR 4:25 M |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH 9/28/46 | 6. AGE (In years last birthday) 22 YRS. | 7c. DATE PRONOUNCED DEAD Month 12 Day 11 Year 1968 |
| 7a. BIRTHPLACE (State or foreign country) Penna. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Washington County Md. |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Labor | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pennsylvania COUNTY Franklin | | 13c. CITY OR TOWN Waynesboro | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 514 W. Seventh St. |
| 14. FATHER'S NAME First Charles Middle Hollingsworth Last Reed | | 15. MOTHER'S MAIDEN NAME First Nettie Middle Reed Last Reed | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16b. SOCIAL SECURITY NO. 164-34-1733 | 17. INFORMANT ADDRESS Waynesboro, Pa. Mr. Robert F. Reed 514 W. 7th St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bilat. 819.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Post surgery for replacement of bone flap (b) Dec. 10, 1968 DUE TO, OR AS A CONSEQUENCE OF (c) cervical trauma following an auto accident 9/15/68 | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sev. days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8254 | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 9/15 1968 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) AUTO ACCIDENT | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Locust & North St | | 21f. LOCATION Street or R.F.D. No. | City or Town HAGERSTOWN County MD State MD |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE Harold G. Gure M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 12/11/68 |
| EXAMINER'S NAME (Type) | | ADDRESS (Street, city, town, or county) | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 12/13/1968 | 23c. NAME OF CEMETERY OR CREMATORY Burns Hill | 23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin, Penna. | |
| 24. FUNERAL DIRECTOR Harold G. Gure ADDRESS Waynesboro, Penna. | | 25a. REC'D BY REGISTRAR DEC 16 1968 | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18371 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 18384 | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) JOHANNES | | | | | First Middle Last | | | | | 2a. DATE OF DEATH 12.9.68 | | | | | 2b. HOUR 3 p M | | | | | | | | | |
| 3. SEX MALE | | | | | 4. RACE WHITE | | | | | 5. DATE OF BIRTH DEC.23, 1891 | | | | | 6. AGE (In years last birthday) 76 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country) HOLLAND | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH WASHINGTON Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH HANCOCK | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOME | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED NAVY | | | | | 12b. KIND OF BUSINESS OR INDUSTRY NAVY | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | | | | 13b. COUNTY WASHINGTON | | | | | 13c. CITY OR TOWN HANCOCK | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER N.PENNA.AVE. | | | | |
| 14. FATHER'S NAME NOT KNOWN | | | | | 15. MOTHER'S MAIDEN NAME NOT KNOWN | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. 066.07 1165 | | | | | 17. INFORMANT SERENA P HOOGERWERF Address HANCOCK MD. N.PENNA AVE. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min 20 yrs. | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201 | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/19/59 , 19__, to 12/9/68 , 19__, that (I) (we) last saw the deceased alive on 10/22 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE FB Thomas III M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 12/9/68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) FB Thomas III M.D. | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVEMENT (Specify) CREMATION | | | | | 23b. DATE 12.13.68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Cremaory | | | | | 23d. LOCATION (City or Town) (County) (State) Washington, D.C. 20002 | | | | | | | | | |
| 24. FUNERAL DIRECTOR Howard J Stone Hancock Md | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 16 1968 | | | | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|--|--|---|--|-----------------------------------|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Wilbur Earl Huntzberry | | | | | | December 8, 1968 | | 1:00A M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| Male | | White | | April 9, 1921 | | 47 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Pondsville, Md. | | U. S. A. | | | | Washington Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | | Washington Co., Hospital | | | Sanding Rm. Forman | | Furniture | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Washington | | Hagerstown | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Rfd. 1 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| Frank B. Huntzberry | | | Bertha M. Showe | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| Yes | | | W. W. Two | | Mrs. Mary M. Huntzberry, Rfd. 1, Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cerebral thrombosis - Pontine hemorrhage</u> | | | | | | | | | | |
| 4230 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) <u>Cerebral arterio-sclerosis</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) <u>unknown</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 3328 <u>Hypertensive Cardiovascular Disease</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | City or Town | | County State | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 7, 1968</u> , to <u>Dec 8, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 7, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| <u>Edson B. Moody, M.D.</u> | | | | | | | <u>12/9/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | |
| Edson B. Moody, M.D. | | | | | 363 S. Cleveland Ave. Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 12- 10- 68 | | Rest Haven Cemetery | | Hagerstown, Wash. Co., Md. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | | DEC 12 1968 | | <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

| 18373 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18386 | |
|--|--|--|---|--|--|---|---|---|---|--|--|--|-----|--------------------------------|--------------------------------|--------------------------|--|--|--|-------|--|
| Item 5 Film G408 1/9/69 TS | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Edward | | | Middle Lee | | | Last Hutzell | | | 2a. DATE OF DEATH Month Dec. Day 30 Year 1968 | | | | 2b. HOUR 4. AM | | | | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH June 27 1876 1896 | | | | 6. AGE (In years last birthday) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Washington | | | | Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 109 Stouffer Ave. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Woodworker | | | | 12b. KIND OF BUSINESS OR INDUSTRY Pangborn Corp | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Washington | | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 109 Stouffer Ave. | | | | | | | | | | | |
| 14. FATHER'S NAME First John | | | Middle Hutzell | | | Last Susan | | | 15. MOTHER'S MAIDEN NAME First Malinda | | | Middle Cunningham | | | Last Hagerstown, Md. | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | | 16b. SOCIAL SECURITY NO. 215-09-7389 | | | 17. INFORMANT Mrs. Maryada Hutzell | | | 109 Stouffer Ave. Hagerstown, Md. | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardiovascular Disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours 2 yrs 9 mths 3 years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Tracheobronchitis; pulmonary emphysema; diverticulosis-sigmoid. | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 2 , 19 68 , to Dec 30 , 19 68 , that (I) (we) last saw the deceased alive on Dec 28 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE  | | | 22c. DATE SIGNED Dec 30 1968 | | | 22d. PHYSICIAN'S NAME (Type) William T. Layman, M.D | | | | 22e. ADDRESS 301 E. Antietam Street, Hagerstown, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE Jan. 1 1969 | | | 23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Boonsboro Wash. Md. | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Md. | | | 25a. REC'D BY REGISTRAR DATE JAN 3 1969 | | | 25b. REGISTRAR'S SIGNATURE  | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) | | | | First Middle Last | | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR | | |
|---|--|--|--|--|--|---|--|--|------------------------|--|
| Wanda Arlene Jamison | | | | | | December 29, 1968 | | 2:00A M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost, birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | |
| Female | | White | | June 19, 1916 | | 52 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Roxberry, Md. | | U. S. A. | | | | Washington Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | | Washington Co. Hospital | | | Housewife | | Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Washington | | Hagerstown | | | | Rfd. 3 | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| George R. Baker | | | Ida Pearl Long | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No. | | | 212-38-9472 | | Mr. Harvey L. Jamison, Rfd. 3, Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Arteriosclerotic heart disease</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 4200 ronol shut down- etiology unknown | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| none | | - | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. none 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | none | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | none | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>61</u> , to <u>Dec</u> , 19 <u>68</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Dec 29</u> , 19 <u>68</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | |
| <u>Harold R. Tritch, Jr MD</u> | | 12/30/68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | |
| Harold R. Tritch, Jr MD | | 302 N. Potomac St Hagerstown, Md | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 12- 31- 68 | | Cedar Lawn Memorial Park | | Hagerstown, Wash. Co., Md. | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md | | JAN 6 1969 | | <u>Charles Judge</u> | | | | | | |

Serial 18-21-55 Logan County Memorial Park, Hagerstown, Md., Md.

John H. Burt, Jr., 413 W. Main St., Hagerstown, Md.

No.

George H. Burt

Hagerstown, Md.

Hagerstown, Md.

Hagerstown, Md.

Hagerstown, Md.

June 19, 1918

Hagerstown

December 29, 1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>3</div> <div>1</div> <div>18375</div> <div>18388</div> | | | | | | | | | | | |
|---|--|--|---------|--|---|--|--|--|--------|--|-------|
| 1. DECEASED-NAME | | | | | | 2a. DATE OF DEATH | | 2b. HOUR | | | |
| (Type or print) | | First | Middle | Last | | Dec. Month 3 Day 1968 | | Year | | 12:10 AM | |
| Jesse | | Joseph | | Kendall | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | White | | Nov. 2, 1883 | | 85 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Md. | | USA | | | | Washington Co. Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Hagerstown | | Washington County Hospital | | Blacksmith | | Railroad | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | Wash. | | Smithsburg | | | | RD # 2 | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | | |
| William | | I. | Kendall | | Margaret | | S. | Brunner | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | | |
| no | | 705-10-4598A | | Mrs. Eva M. Smith, Chewsville, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiac arrest due to ventricular arrhythmia | | | | | | | | | | instant | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) Myocardial infarctions | | | | | | | | | | 2 years | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) Arteriosclerotic cardiovascular disease | | | | | | | | | | 10 years. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-14, 19 54, to 12-3, 19 68, that (I) (we) last saw the deceased alive on 12-2, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Charles F. Hess | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 12-3-68 | |
| 22d. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D. | | | | | 22e. ADDRESS Smithsburg, Maryland 21783 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | Dec. 5, 1968 | | Smithsburg Cemetery | | Smithsburg Wash. Md. | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. RECEIVED BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Minnich Funeral Home, Smithsburg, Md. | | | | | DEC 6 1968 | | Charles Judge | | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form. PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| 18376 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18389 | | | | | | | | |
|--|--|---------|--|------------------|--|---|--|--------------------------------|---|--|------------------|--|--|-----------------|---|--|----------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF ESTI- DEATH MATED | | | Month Day Year | | 2b. HOUR 10 M | | | | | | | |
| MARY ELIZABETH KLINE | | | | | | Dec 29 19 68 | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | 2c. DATE PRONOUNCED DEAD Month Day Year | | 2d. HOUR 5 M | | | | |
| Female | | White | | Dec 12 1901 | | 67 YRS | | | | | | Dec 29 1968 | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | |
| Maryland | | | U.S.A. | | | | | | Washington | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Funkstown | | | 10 W. Poplar St | | | Housewife | | | Home | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER | | | | | | |
| Maryland | | | Washington | | | Funkstown | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 10 West Poplar St | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | |
| Fred Feigley | | | | | Mary Green | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS | | | | | | | | |
| No | | | | | 214-09-4858 | | | | | Paul A? Kline 1635 Timberlane | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 471X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 480X (b) Pneumonia Secondary to Influenza (c) 7-10 days | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | |
| Large Venial Hemica | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | | | | Edward W. Dittoii M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) | | | 22b. DATE SIGNED 12-30-68 217 W. Washington ST. Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | | | 1/1/69 | | | | | Rose Hill Cemetery | | | | | Hagerstown Wash Co Md | | | |
| 24. FUNERAL DIRECTOR | | | | | Hagerstown Md. | | | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | |
| Andrew K. Coffman Funeral Home Inc | | | | | | | | | | JAN 6 1969 | | | | | Charles Judge | | | |

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Andrew K. Coleman funeral home inc
111 Hill Cemetery
Washington Wash Dc

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18377 | | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 18390 | |
|---|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED-NAME (Type or print) | | First Middle Last Grady Knapp | | 2a. DATE OF DEATH Month Day Year December 15 1968 | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH Sept. 1, 1904 | |
| 7a. BIRTHPLACE (State or foreign country) W. Va. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Laborer | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Myersville | |
| 14. FATHER'S NAME First Middle Last John Austin Knapp | | 15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Rebecca Tyree | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no | | 16b. SOCIAL SECURITY NO. (If give war or dates of service) 215-12-2504 | | 17. INFORMANT Address Mrs. Earnie N. Knapp, Myersville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive and Arteriosclerotic Heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443x Chronic bronchitis and pulmonary emphysema | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 3, 1968, to Dec 15, 1968, that (I) (we) last saw the deceased alive on Nov 14 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Charles C. Spencer M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED 12-15-68 | |
| 22d. PHYSICIAN'S NAME (Type) Charles C. Spencer | | | | 22e. ADDRESS 145 S. Prospect St. Hagerstown | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Dec. 18, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Salem United Methodist Wolfsville, Fred. Co. Md. | |
| 24. FUNERAL DIRECTOR ADDRESS Paul F. Bittle, Myersville, Md. | | 25a. REC'D BY REGISTRAR DATE DEC 19 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

18330

SECTION OF DATA

Section is 18330

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Polymers and
Hypertensive and Antihypertensive
Drugs

Chronic Bronchitis and Pulmonary Emphysema

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15(4)
30M REV. 1/68

MEDICAL CERTIFICATION

| | | | | | | | | |
|--|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR | |
| MARY | | FRANCES | LESHER | DECEMBER 25 1968 | | 9:30 P.M. | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| FEMALE | WHITE | | 9/15/1880 | | 88 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| MARYLAND | U.S.A. | | | | WASHINGTON | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| HAGERSTOWN | WASHINGTON CO. HOSPITAL | | HOUSEWIFE | | HOME | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | WASHINGTON | | HAGERSTOWN | | X | | 1905 GAY ST. | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| JOHN CYRUS MOORE | | | AMANDA GROVE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| NO | | NONE | | MR. FREDERICK C. LESHER | | HAGERSTOWN MD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma Carcinoma of Sigmoid Colon & Ad. Intestines</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>3+ yrs.</i> DUE TO, OR AS A CONSEQUENCE OF (c) 1533 | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerotic Cardiac Dis.</i> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12 May 1965</i> , to <i>25 Dec 1968</i> , that (I) (we) last saw the deceased alive on <i>25 Dec 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <i>Richard T. Binford</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 26 Dec. 68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | |
| Richard T. Binford M.D. | | 1135 Potomac Ave. - Hagerstown, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| BURIAL | | 12/28/68 | | REST HAVEN CEM. | | HAGERSTOWN WASH. MD. | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| W. J. Harment, Hagerstown, Md. | | DEC 31 1968 | | Charles Judge | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18379

18392

| | | | | | | | | | | |
|---|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) Donna Mae Long | | | 2a. DATE OF DEATH Month December Day 23 Year 1968 | | | 2b. HOUR M | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH August 4, 1939 | | | 6. AGE (In years last birthday) 29 YRS. | | IF UNDER 1 YEAR MONTHS 29 DAYS 29 HOURS 29 MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Hagerstown, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None | | | 12b. KIND OF BUSINESS OR INDUSTRY None | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 481 Mitchell Ave. | |
| 14. FATHER'S NAME First George Middle C Last Long, Sr. | | | 15. MOTHER'S MAIDEN NAME First Frances Middle Grace Last Turner | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mr. Geo. Long 481 Mitchell Ave. Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia & Pyrexia 470X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Flu DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 1 wk | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 481X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 20 Dec, 1968 , to 23 Dec, 1968 , that (I) (we) last saw the deceased alive on 23 Dec 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE J.D. Wilson, M.D. | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 12/24/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) J.D. Wilson M.D. | | | 22e. ADDRESS 580 Northern Ave. Hagerstown, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 12/28/68 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington-Md. | | | |
| 24. FUNERAL DIRECTOR Wm. G. Host | | | ADDRESS Rest Haven Funeral Chapel Hagerstown, Md. | | | 25a. REC'D BY REGISTRAR DATE DEC 30 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | |

1958

1958

W. C. Hunt

1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|--|--|---|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 621 Maryland Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Woodrow Wilson Lynch | | | | | 4. DATE OF DEATH December 24 1968 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 21, 1916 | | 9. AGE (In years, last birthday) 52 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool maker | | 10b. KIND OF BUSINESS OR INDUSTRY Pangborn Corp. | | 11. BIRTHPLACE (County & State, or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Homer Blaine Lynch | | | | | 14. MOTHER'S MAIDEN NAME Dammie Frances Bolder | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 235-18-7443 | | 17. INFORMANT Mrs. Mildred Lynch-Hagerstown, Maryland | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2500 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X DUE TO Coronary Artery Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 11-23 19 68 to 12-24 19 68 that (I) (we) last saw the deceased alive on 12-24 19 68 , and that death occurred at 9:00 A.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE E. J. Lutz | | | | | 22b. DATE SIGNED 12-26-68 | | | | |
| 22c. PHYSICIAN'S NAME (Type) E. J. Lutz, M.D. | | | | | 22d. ADDRESS 300 U. S. National Highway, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 27, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery | | 23d. LOCATION (City, town or county) (State) Martinsburg West Virginia | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown | | | | | 25a. REC'D BY REGISTRAR DEC 30 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |
| Brown Funeral Home-Martinsburg, West Virginia | | | | | | | | | |

1930

CERTIFICATE OF DEATH

1930

Age 70

Married

Married

Married

Washington County Hospital

221 Maryland Avenue

December 30

Branch

Branch

Branch

George M. J. Jr.

White

Male

Branch

White

George M. J. Jr.

Branch

White

330-1-1443

Branch

White

DEC 30 1930

Branch

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15(4)
30M REV. 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18381

CERTIFICATE OF DEATH

18394

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) Lucia | | First Mancini | | Middle | | Last | | 2a. DATE OF DEATH Month December Day 22 , Year 1968 | | 2b. HOUR 8:30 A M | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH 12-13-1892 | | 6. AGE (In years last birthday) 76 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (State or foreign country) Italy | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 55 E. Franklin, St. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Wash. | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 55 E. Franklin, St. | | | |
| 14. FATHER'S NAME First Pietro D. Adamo Middle Adamo Last Adamo | | | | 15. MOTHER'S MAIDEN NAME First Rosaria Middle LaVergetta Last LaVergetta | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Address Mr. Pietro Mancini Hagerstown, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1962 IMMEDIATE CAUSE (a) Retrosplenetic Sarcoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 158x (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14-15 mo | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Retrosplenetic C.V. Disease - Distal Metastases | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. 14 E. 55 | | City or Town Hagerstown | | County Washington | | State Md. | |
| 22a. I certify that (I) (this hospital) attended the deceased from 14 Feb , 1963, to 22 Dec , 1968, that (I) (we) last saw the deceased alive on 16 Dec , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Wm. Noel Fenwick | | DEGREE MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 23 Dec 1968 | |
| 22d. PHYSICIAN'S NAME (Type) Wm. Noel Fenwick | | 22e. ADDRESS 218 N. Potomac St. Hagerstown, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12-27-68 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City or Town) Hagerstown, Md. | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE DEC 27 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | |

1933

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

1933

RECEIVED

1933

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

1933

RECEIVED

UNITED STATES DEPARTMENT OF AGRICULTURE



1933

UNITED STATES DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-7-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|---|---|--|---|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last Ethel Louise Miller | | | 2a. DATE OF DEATH Month Day Year Dec. 22, 1968 | | | 2b. HOUR M | | | | | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH Aug. 6, 1888 | | 6. AGE (In years last birthday) 80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Jackson Con. Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Hair Dresser | | 12b. KIND OF BUSINESS OR INDUSTRY Self Employed | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 1006 Potomac Ave. | | | |
| 14. FATHER'S NAME First Middle Last Perry W. Miller | | | 15. MOTHER'S MAIDEN NAME First Middle Last Minnie Valentine | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address Dr. Althea Miller, Hagerstown, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4129 Pulmonary edema - IMMEDIATE CAUSE (a) Anterograde Cardiac Dis. DUE TO, OR AS A CONSEQUENCE OF (b) years DUE TO, OR AS A CONSEQUENCE OF (c) last 4221 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cerebral thrombosis & right hemisphere (3 yrs) about 3 months | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2008 , to date , 19 68 , that (I) (we) last saw the deceased alive on 22 days 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Richard T. Binford | | | | | DEGREE MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 23 Dec. 1968 | | |
| 22d. PHYSICIAN'S NAME (Type) Richard T. Binford | | | | | 22e. ADDRESS 1135 Potomac Ave., Hagerstown, Md. 21740 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVED | | 23b. DATE 12-26-68 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. | | | | | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md. | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE DEC 27 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR M | |
| URSULA MAY MILLER | | | | | | December 1, 1968 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | White | | Aug. 12, 1896 | | 72 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Virginia | | U.S.A. | | | | Washington | | Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | Washington Co. Hospital | | House Wife | | Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Washington | | Hagerstown | | | | 308 S. Cleveland Ave. | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Carl F. Harper | | | Frances Lambert | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| None | | None | | Earl Miller | | 308 S. Cleveland Ave Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>331X</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>1 Dec</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov 19</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>J.D. Wilson</u> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>12/2/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) J.D. Wilson Md. | | | | 22e. ADDRESS <u>880 Northrn Ave Hagerstown, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, <u>Don't know</u> | | 23b. DATE <u>Dec. 4, 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Hagerstown, Md</u> <u>Andrew K. Coffman Funeral Home Inc.</u> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE <u>DEC 3 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u> | |

10332

CRIMINAL RECORD

December 1, 1958

WILLIS

RAY

URGULA

13

Aug. 17, 1950

White

Female

Washington

U.S.A.

Virginia

Hagerstown

Washington Co. Hospital

House Wife

1st. Term

Maryland

Washington

Hagerstown

x

308 E. Cleveland Ave.

Carl F. Harper

Frances Lebert

no

none

none

Ball Miller

308 E. Cleveland Ave.
Hagerstown, Md.

580 Northern Ave. Hagerstown, Md.

J.D. Wilson Md.

Hagerstown, Md.

Case 411 Registry

Enlist Dec. 4, 1958

Hagerstown, Md.

Andrew K. Collins Funeral Home Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115-141
20M-141

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
18384
CERTIFICATE OF DEATH

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 Week d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash Co. Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R.F.D.2, Clear Spring, Md. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Lela May Mills | | 4. DATE OF DEATH Month Dec. Day 16th. Year 1968 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 12, 1889 |
| 9. AGE (In years last birthday) 79 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 79 Days 16 Hours 16 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Wash. Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Alvin Myers | | 14. MOTHER'S MAIDEN NAME Emma Myers | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 218-34-4030A | |
| 17. INFORMANT Raymond Mills | | Address R.D.2, Clear Spring | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 402X Arteriosclerosis DUE TO (b) Hypertensive Heart Disease DUE TO (c) 443X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Dec 16 , 19 68 , to Dec 16 , 19 68 , that (I) (we) last saw the deceased alive on Dec 16 , 19 68 , and that death occurred at 11 M, from the causes and on the date stated above. 22a. SIGNATURE Francis Rosillo M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) FRANCIS ROSILLO 22d. ADDRESS 386 Guilford Ave. Wg 22b. DATE SIGNED DEC 23 1968 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Dec. 19, 68 23c. NAME OF CEMETERY OR CREMATORY St. Paul 23d. LOCATION (City, town or county) (State) Clear Spring, Md. 24. FUNERAL DIRECTOR Donald E. Thompson ADDRESS Thompson Funeral Home Clear Spring, Md. 25a. REC'D BY REGISTRAR DEC 23 1968 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

Thompson, General Home Clear Spring, Md. Dec. 19, 61 St. Paul
 Clear Spring, Md.

218-34-4030A Raymond Miller R.D. 2, Clear Spring

John Myers

John Myers

Houswife

Home

Leah, Maryland

U.S.A.

Female white

X

Dec. 12, 1989 79

Leah

May

Miller

Dec. 1989

Wash Co. Hospital

Negate own

1 week

R.R.D. 2, Clear Spring, Md.

Maryland

Washington

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1003. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER:
 necessary, please execute the cert-
 the funeral director. Page 4 should
 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

X

9.

VR A15ME (9)
10M REV. 1/68

REGISTRAR'S SIGNATURE
J. Charles Judge

18328

RECEIVED

18328

18328

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

| <div>18396</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>18399</div> | | | | | | | | | | | | |
|---|--|--|--|---|---------------------------------|--|---|--|---|------------------------------|--------------------------------|--|
| 1. DECEASED-NAME (Type or print) ^{First} KITTY ^{Middle} MARIE ^{Last} MULLENIX | | | | | | 2a. DATE OF DEATH DECEMBER 30 Day 1968 | | | 2b. HOUR 7 a.m. | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH 8/5/1895 | | | 6. AGE (In years last birthday) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON | | | Md. | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital state or foreign) WASHINGTON CO. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of life, or if retired.) HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | | | |
| 13a. USUAL RESIDENCE (Where deceased admission) MARYLAND | | | 13b. WASHINGTON | | 13c. CITY OR TOWN HAGERSTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 605 W. FRANKLIN ST. | | | |
| 14. FATHER'S NAME ^{First} CLINTON ^{Middle} ^{Last} TROVINGER | | | | 15. MOTHER'S MAIDEN NAME ^{First} SUSAN ^{Middle} STOCKS ^{Last} LAGER | | | | HAGERSTOWN MD. | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. NONE | | 17. INFORMANT MR. LEWIS H. MULLENIX | | | | HAGERSTOWN MD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute PNEUMONIA</u> 1829 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Coronary artery disease</u> (b) <u>Coronary artery disease</u> (c) <u>Primary heart</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 174X | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-29-68, 1968, to Dec 30, 1968, that (I) (we) last saw the deceased alive on 12-29-68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>E. R. Landig</u> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 12-30-68 | | |
| 22d. PHYSICIAN'S NAME (Type) E. R. Landig | | 22e. ADDRESS 300 G. B. Kays, Hagerstown Md. | | | | | | | | | | |
| 23a. BURIAL-CREMATATION, (Indicate All that Apply) | | 23b. DATE 1/1/69 | | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM. | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD. | | | | | | |
| 24. FUNERAL DIRECTOR <u>W. F. Norment</u> | | ADDRESS Hagerstown, Md. | | 25a. REC'D BY REGISTRAR DATE JAN 3 1969 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 409 Maryland State Department of Health DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18400

| | | | | | | | | | | | | | | |
|--|---------|------------------|--|--------------------------------|--|---|--|--------------------------|---|--|----------|---|---|--|
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH ESTI- MATED | | | Month Day Year | | | 2b. HOUR 10A M | | |
| William Howard Naylor | | | | | | 12 26 68 | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | | |
| Male | White | Aug. 18, 1910 | 58 YRS. | | | | | Month Day Year | | | 1230 P | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | | |
| Maryland | | | U.S.A. | | | | | | Washington | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Highfield | | | Box 3 | | | Labor | | | Plumbing | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER | | |
| Maryland | | | Washington | | | Highfield | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | Box 3 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| First Middle Last | | | First Middle Last | | | no | | | 218-07-2667 | | | Miss Helen Naylor Box 3, Highfield, Md. | | |
| W. Reuben Naylor | | | Maude V. Cline | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PENDING Thrombotic occlusion of circumflex</u> DUE TO, OR AS A CONSEQUENCE OF <u>branch of left coronary artery</u> (b) <u>Coronary atherosclerosis, moderately advanced</u> DUE TO, OR AS A CONSEQUENCE OF <u>Thrombotic occlusion of right</u> (c) <u>coronary artery, recent</u> | | | | | | | | | | | | | Several min 5 yrs. Recent | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 4201 | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | 22b. DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | 12-26-68 | | | | | |
| DR. E.W. DITTO, JR. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | ADDRESS (Street, city, town, or county) Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | 12/28/1968 | | | St. John | | | Sabillasville, Frederick, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| David Y. Guare | | | Waynesboro, Penna. | | | | | | DEC 30 1968 | | | | | |

12660

MEMORANDUM FOR THE DIRECTOR

DATE: 12/15/58

TO: SAC, NEW YORK (100-100000)
FROM: SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows, appearing to be a memorandum format with various fields and possibly a signature block.]

[Large block of illegible text, likely the main body of the memorandum or a series of paragraphs.]

11-15-58

DR. E.W. DITTO, JR.

12/15/58
[Illegible text at the bottom of the page, possibly a footer or additional administrative markings.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

18388

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18401

| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED-NAME (Type or print) Esther Stewart Newcomer | | | 2a. DATE OF DEATH Month Dec. Day 7 Year 1968 | | 2b. HOUR 4:45 PM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH March 26 1908 | | 6. AGE (In years last birthday) 60 YRS. | IF UNDER 1 YEAR MONTHS 8 DAYS 10 |
| 7a. BIRTHPLACE (State or foreign country) Ohio | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Washington Md. | | |
| 10. CITY OR TOWN OF DEATH Williamsport | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 15 W. Salisbury St. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY home |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. COUNTY Washington | 13c. CITY OR TOWN Williamsport | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET AND NUMBER 15 W. Salisbury St. | |
| 14. FATHER'S NAME First Middle Last Barclay Stewart | | 15. MOTHER'S MAIDEN NAME First Middle Last Leila Campbell | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) No (If yes give war or dates of service) ----- | | 16b. SOCIAL SECURITY NO. 220-16-3836 | 17. Williamsport Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 4100 DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction due to coronary artery occlusion DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardiovascular disease | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 12 hours 7 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 None | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (the hospital) attended the deceased from 05/06/61 , 19__, to 12/07/68 , 19__, that (I) (we) last saw the deceased alive on 12/07/68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) view the body after death. | | | | | |
| 22b. SIGNATURE Archie Robert Cohen M.D. DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED 12/09/68 | |
| 22d. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D. | | 22e. ADDRESS Clear Spring, Maryland 21722 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Dec. 10-68 | 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery | | 23d. LOCATION (City or Town) (County) (State) Williamsport Wash. Md. | |
| 24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE DEC 13 1968 | 25b. REGISTRAR'S SIGNATURE Charles Judge |

10401

RECEIVED OF DEATH

[Handwritten signature]

10401

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18389 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18402 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First LEE | | | | | | | | | | Middle ROY | | | | | | | | | | Last PITTMAN | | | | | | | | | | 12 Month 7 Day 68 | | | | | | | | | | M | | | | | | | | | | | | | | | | | | | |
| 3. SEX MALE | | | | | | | | | | 4. RACE WHITE | | | | | | | | | | 5. DATE OF BIRTH 4.11.1890 | | | | | | | | | | 6. AGE (In years last birthday) 78 YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) PENNA. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH WASHINGTON MD. | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH HANCOCK | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOME | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED STATE RD. | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | | | | | | | | | 13b. COUNTY WASHINGTON | | | | | | | | | | 13c. CITY OR TOWN HANCOCK | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER 107 FULTON ST. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last WILLIAM PITTMAN | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last SARAH E HESS | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. 212.10.8500 | | | | | | | | | | 17. INFORMANT DELLA B PITTMAN | | | | | | | | | | Address HANCOCK MD. 107 FULTON ST. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260x | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min 10 yrs 18 yrs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/12/60, 19, to 11/18, 1968, that (I) (we) lost saw the deceased alive on 11/18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE F B Thomas III M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 12/9/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) F B Thomas III M.D. | | | | | | | | | | 22e. ADDRESS HANCOCK, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REINTERMENT BURIAL | | | | | | | | | | 23b. DATE 12.10.68 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY DEMASCUS | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) RURAL FULTON COUNTY PENNA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Harold J. Snow | | | | | | | | | | ADDRESS Hancock, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 12 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

18402

UNITED STATES DEPARTMENT OF JUSTICE

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U.S.A.

PENNA.

RETIRED STATE PD.

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HANCOCK

107 FULTON ST.

WASHINGTON HANCOCK

NO.

3000

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SIS. 10. 1920 DELA B PITMAN 107 FULTON ST.

NO.

[Faint, illegible handwritten notes and signatures]

[Faint, illegible handwritten notes and signatures]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18390

18403

| | | | | | | | | |
|--|-------------------------|--|--|---|---|--|--|---|
| 1. DECEASED-NAME (Type or Print) OLEN ALBERT POOLE | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year 12/21/1968 | | | 2b. HOUR 8:AM | | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH 2/9/1901 | 6. AGE (in years last birthday) 67 YRS. | IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD Month 12 Day 21 Year 1968 | | |
| 7a. BIRTHPLACE (State or foreign country) N. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 92 W. WASHINGTON ST | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CARPENTER | | 12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY WASHINGTON | | 13c. CITY OR TOWN HAGERSTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 92 W. WASHINGTON |
| 14. FATHER'S NAME First J. Middle HEMING Last POOLE | | | 15. MOTHER'S MAIDEN NAME First LAURA Middle CARICO Last CARICO | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-16-9259 | | 17. INFORMANT MARY SHIPLEY ADDRESS RFD#1 Bx377 ABERDEEN MARYLAND | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) CORONARY ATHEROSCLEROSIS WITH OCCLUSION OF ANTERIOR DESCENDING PERICARDITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) LOBULAR PNEUMONIA, EARLY (c) LOBULAR PNEUMONIA, EARLY | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE D. E. W. DITTO, JR. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 12/21/68 | | |
| EXAMINER'S NAME (Type) DR. E. W. DITTO, JR. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 12/23/68 | | 23c. NAME OF CEMETERY OR CREMATORY CAK GROVE CHURCH CEMETERY | | 23d. LOCATION (City or Town) (County) (State) BELAIR Md. | | |
| 24. FUNERAL DIRECTOR FOSTER FUNERAL HOME | | | ADDRESS BELAIR MARYLAND | | | 25a. REC'D BY REGISTRAR DEC 30 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge |

DEC 30 1960

DR. E. W. DITTO, JR.

X

12/21/60

X

X

LOBULAR PNEUMONIA, EARLY

PERICARDITIS

CORONARY ATHEROSCLEROSIS WITH OCCLUSION DISTANT
OF ANTERIOR DESCENDING

104403

X 12/21/60

21

12

68

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------------------------|--|---|---|--|--|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) Edward Harry Queen | | | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year Dec 25 19 68 | | | 2b. HOUR OF ESTI-DEATH MATED 4:30 P M | | | |
| 3. SEX Male | 4. RACE Colored | 5. DATE OF BIRTH 2-17-1897 | 6. AGE (In years last birthday) 71 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year 12-25-68 19 4:30 P M | | 2d. HOUR | |
| 7a. BIRTHPLACE (State or foreign country) New York, N.Y. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 621 Pennsylvania Ave | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Railroad | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 621 Pennsylvania Ave | | |
| 14. FATHER'S NAME First Middle Last Unknown | | | 15. MOTHER'S MAIDEN NAME First Middle Last Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | 16b. SOCIAL SECURITY NO. World War 1 214-16-0919 | | 17. INFORMANT ADDRESS Mrs. Juanita C. Queen 621 Penna Ave | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Esophagus 150 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 150 X | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE J. E. W. Hitt | | | M.D. | | | 22b. DATE SIGNED 12-27-68 | | | |
| EXAMINER'S NAME (Type) J. E. W. HITT | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12-28-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Md. | | | |
| 24. FUNERAL DIRECTOR John R. Watson of Hagerstown Md. | | | | 25a. REC'D BY REGISTRAR DATE DEC 31 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

20380

1954-1955

DEC 1 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18392 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18405 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maurice Irving Reece | | | | | | | | | | December 15 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| Male | | | | | | | | | | White | | | | | | | | | | September 4, 1889 | | | | | | | | | | 79 YRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| Brooklyn, N.Y. | | | | | | | | | | USA | | | | | | | | | | | | | | | | | | | | Washington | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bunktown | | | | | | | | | | 37 W. Baltimore St. | | | | | | | | | | Heating Contractor | | | | | | | | | | Buildings | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | Washington | | | | | | | | | | Bunktown | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 37 W. Baltimore St. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Stanley M Reece | | | | | | | | | | Cissie L Harne | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT Address | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | 214-09-8032 | | | | | | | | | | Mrs. Bob Creager 37 W. Baltimore St. Bunktown. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | 4109 | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | 75 min | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | arteriosclerotic heart disease 1 year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | 4201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-2, 19 67, to Dec 11, 19 68, that (I) (we) last saw the deceased alive on 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. P. Lardis, M.D. | | | | | | | | | | 301 N. Roxanne, Hagerstown, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | 12/18/68 | | | | | | | | | | Rest Haven Cemetery | | | | | | | | | | Hagerstown-Washington-Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wm. C. Woody | | | | | | | | | | DATE DEC 19 1968 | | | | | | | | | | f Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rest Haven Funeral Chapel Hagerstown, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

18402

Office of the

Secretary of the

Department of the

Interior, 1889

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W. C. Wood

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
18393 CERTIFICATE OF DEATH 18406

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagers Town</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hancock MD RD2</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>James Roscoe Reel Jr.</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>1968</u> | | 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 17 1922</u> | | 9. AGE (In years last birthday) <u>46</u> yrs. <u>8</u> Months <u>1</u> Days <u>19</u> Hours <u>15</u> Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Stone & Concrete</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co - MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | | 13. FATHER'S NAME <u>James R Reel Sr.</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-32-3673</u> | | 17. INFORMANT <u>Mrs. Mary J Reel</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured acute dissecting aneurysm of aorta</u> 441.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>451X</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/16, 1968</u> , to <u>12/17, 1968</u> , that (I) (we) last saw the deceased alive on <u>12/17, 1968</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>John H. Horn Baker</u> | | | | 22b. DATE SIGNED <u>12-18-68</u> | | 22c. PHYSICIAN'S NAME (Type) <u>JOHN H. HORN BAKER</u> | |
| 22d. ADDRESS <u>154 W. Washington St. Hagerstown - Md</u> | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | |
| 23b. DATE THEREOF <u>Dec. 20 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Tonoloway</u> | | 23d. LOCATION (City, town or county) (State) <u>Fulton Pa.</u> | | 24. FUNERAL DIRECTOR <u>Howard Spies</u> | |
| 24b. ADDRESS <u>Harrisonville, Pa.</u> | | 25a. REC'D BY REGISTRAR <u>DEC 23 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

MEDICAL CERTIFICATION

08408

08408

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>7</div> <div>1</div> <div>18394</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>18407</div> | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME (Type or print) | | | | First Middle Last | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | |
| Vina | | | | Virginia Rhoe | | | | 12 Month 24 Day 68 Year | | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| female | | white | | May 18, 1905 | | | | 63 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| W. Va. | | USA | | | | Washington Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | | | Wash. Co. Hospital | | | | housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | | | Wash. | | Hagerstown | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 759 W. Washington St. | | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | |
| Hammond Allright | | | | Mamie Lutman | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | | |
| no | | | | none | | James Rhoe Hagerstown, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> | | | | | | | | | | | | 21 hrs | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Exhaustion</u> | | | | | | | | | | | | 24 hrs | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Long latent disease</u> | | | | | | | | | | | | Several years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 332x | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/24/68</u> , 19 <u>68</u> , to <u>12/24/68</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>12-24-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | 22c. DATE SIGNED <u>12-27-68</u> | |
| 22d. PHYSICIAN'S NAME (Type) <u>L. E. W. H. T. T. G. J. R.</u> | | | | | | | | | | | | 22e. ADDRESS <u>215 W. Washington Hagerstown Md</u> | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| burial | | 12-27-68 | | Providence Cemetery | | Providence, W. Va. | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Minnich Funeral Home Hagerstown, Md. | | | | DATE DEC 30 1968 | | <u>[Signature]</u> | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, in any event, within 72 hours after death.

| 18395 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18408 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| First Middle Last GROVER C. RICHESSON | | | | | | | | | | Month Day Year Dec. 29, 1968 | | | | | | | | | | 11:30 P.M. | | | | | | | | | |
| 3. SEX Male | | | | | 4. RACE White | | | | | 5. DATE OF BIRTH Apr. 24, 1888 | | | | | 6. AGE (In years last birthday) 80 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Penna. | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH Washington Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Avalon Manor | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tannery worker | | | | | 12b. KIND OF BUSINESS OR INDUSTRY Leather | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pa. | | | | | 13b. COUNTY Franklin | | | | | 13c. CITY OR TOWN Mercersburg | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER 122 S. Park Ave. | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last William Richesson | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Rebecca Speck | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no | | | | | 16b. SOCIAL SECURITY NO. 159-09-6603 | | | | | 17. INFORMANT Address Mrs. Eugene Lowans Mercersburg, Pa. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks. 2 yrs. | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-12</u> , 19 <u>68</u> , to <u>12-29</u> , 19 <u>68</u> , that (I) (<u>we</u>) lost saw the deceased alive on <u>12-27</u> , 19 <u>68</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Clayton A. Hoffman</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 12/30/68 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman | | | | | | | | | | 22e. ADDRESS 214 N. Potomac St. Hagerstown, Md. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | 23b. DATE 1/1/69 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Fairview | | | | | 23d. LOCATION (City or Town) (County) (State) Mercersburg Franklin, Pa. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>W. L. Linniger</u> ADDRESS Mercersburg, Pa. | | | | | | | | | | 25a. REG. REGISTRAR JAN 6 1969 | | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | |
|--|---------|---|------------------|---|-------------------------------------|---|--------------------------------|---|
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR | |
| STANLEY | | | BLISS | RILEY | DECEMBER 29 68 | | 4:40aM | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| MALE | WHITE | | JUNE 19, 1880 | | 88 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| MARYLAND | | U.S.A. | | WASHINGTON | | Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| HAGERSTOWN | | WASHINGTON COUNTY HOSP. | | RETIRED SUPT. | | W.M. R.R. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| MARYLAND | | WASHINGTON | | HAGERSTOWN | | | | 1019 OAK HILL AVE. |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | First Middle Last | | | | | | |
| JOHN H RILEY | | MARIA BROWNING | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| NO | | 717-10-4071 | | RT #5 Address BOX 191 VIRGINIA HANWAY GRAFTON, WEST VIRGINIA | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> | | | | | | | | Instant |
| 600X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>610X</u> | | | | | | | | |
| (b) <u>Pelvic thrombosis</u> | | | | | | | | Not known |
| (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| <u>Arteriosclerotic heart disease; benign prostate hypertrophy</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 12/6/68 | | Benign prostate hypertrophy | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from <u>Dec. 2</u> , 19 <u>68</u> , to <u>Dec. 29</u> , 19 <u>68</u> , that (I) was last saw the deceased alive on <u>Dec. 28</u> 19 <u>68</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED |
| <u>B.B. Kneisley M.D.</u> | | | | <input checked="" type="checkbox"/> | | | | 12/30/68 |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | |
| B.B. KNEISLEY, M.D. | | 148 W. WASHINGTON ST., HAGERSTOWN, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| BURIAL | | 1/1/69 | | REST HAVEN CEMETERY | | HAGERSTOWN, WASHINGTON, MD. | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | |
| <u>Charles M. Leuzer</u> | | HAGERSTOWN, MARYLAND | | JAN 2 1969 | | <u>Charles Judge</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|-------------------|--|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Helen Rebecca Robinson | | | | | | Month Day Year | | 11:35 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birth day) | | IF UNDER 1 YEAR | |
| female | | white | | 3-21-1891 | | 77 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | |
| Pennsylvania | | USA | | | | Washington Md. | | Hagerstown | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | |
| Avalon Manor | | Stitcher | | Shoe, Mfg. | | Md. | | Wash. | |
| 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | |
| Hagerstown | | | | 55 E. Franklin, St. | | First Middle Last | | First Middle Last | |
| William Shirey | | Katherine Heffelman | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 214-09-5493 | | Mrs. Evelyn Morrison Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cystitis-Pyelitis | | | | | | | | 4 days | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) Chronic Urinary Retention | | | | | | | | 8 weeks | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Brain Syndrome due to old C.V.A., Hypertensive & Atherosclerotic Heart Disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | City or Town | | County State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 30, 1968, to Dec 3, 1968, that (I) (we) lost saw the deceased alive on Dec 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | 22d. ADDRESS | | | |
| William T. Layman, M.D. | | | | Dec 4 1968 | | 301 E. Antietam Street, Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | |
| Burial | | 12-6-1968 | | Rose Hill Cemetery | | Hagerstown, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Minnich Funeral Home Hagerstown, Md. | | | | DATE DEC 9 1968 | | Charles Judge | | | |

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THE OFFICE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18398

18411

| | | | | | | | | | | | |
|---|--|--|---|---|---|---|---|---|--|--------------------------------|--|
| 1. DECEASED-NAME (Type or print) Eva First Monroe Middle Rowe Last | | | 2a. DATE OF DEATH 12 Month 20 Day 68 Year | | | 2b. HOUR M | | | | | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH Dec. 14, 1918 | | 6. AGE (In years last birthday) 50 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Wrapper | | | 12b. KIND OF BUSINESS OR INDUSTRY Bread Co. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Wash. | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 926 Salem Ave. | | |
| 14. FATHER'S NAME First Charles Middle Spidelle Last | | | 15. MOTHER'S MAIDEN NAME First Susan Middle Hart Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 213-16-1567 | | 17. INFORMANT Address Woodrow Rowe Hagerstown, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 284X Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2924 (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Aplastic Anemia | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Days 2 Days 1 Year | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Probable Streptococcal Septicemia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-18, 1961 , to 12-26, 1968 ; that (I) (we) last saw the deceased alive on 12-25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Charles F. Hess M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 12-27-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D. | | | | | | 22e. ADDRESS Smithsburg, Maryland 21783 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE 12-28-68 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md. | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 31 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18399 | | | | | | | | | | 18412 | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | |
| First John Middle Amos Last Rowland | | | | | | | | | | Month December Day 13, Year 1968 2b. HOUR 12:37 AM | | | | | | | | | |
| 3. SEX male | | | 4. RACE white | | | 5. DATE OF BIRTH 10-26-1904 | | | 6. AGE (In years last birthday) 64 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN | | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Washington Md. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. County Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Guard | | | 12b. KIND OF BUSINESS OR INDUSTRY Correctional Inst | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Wash. | | | 13c. CITY OR TOWN Hagerstown | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER 4 Hampton, Road | | | | | | | |
| 14. FATHER'S NAME First Issac D. Middle Rowland Last | | | | | 15. MOTHER'S MAIDEN NAME First Lydia M. Middle Shank Last | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. WW 11 | | | 17. INFORMANT Address Mrs. Janice K. Rowland Hagerstown, Md. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation | | | | | | | | | | 1 1/2 hours | | | | | | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction | | | | | | | | | | 1 1/2 hours | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | |
| 4201 none | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1962 to Dec 13, 1968, that (I) (we) last saw the deceased alive on Dec 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE M.E. Byrkit | | | | | | | | | | 22c. DATE SIGNED Dec 14, 1968 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) M.E. Byrkit | | | | | | | | | | 22e. ADDRESS Williamsport Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | | 23b. DATE 12-15-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Quincy Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Quincy, Pennsylvania | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md. | | | | | 25a. REC'D BY REGISTRAR DATE DEC 16 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | |

1941

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1941

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in", "to", "from" are visible.]

1

2

3

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | |
|--|---------|---|--------|--|---|---|-----------------------------------|---|------|----------|
| 1. DECEASED-NAME (Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF ESTI- DEATH MATED | | Month | Day | Year | 2b. HOUR |
| GEORGE | | JAMISON | RUCH | | <input checked="" type="checkbox"/> 12 | | 12 | 10 | 1968 | 9:14 |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 24 HRS DAYS | 2c. DATE PRONOUNCED DEAD Month | | Day | Year |
| Male | W | NOVEMBER 17, 09 | | 59 YRS. | | | 12 | | 10 | 1968 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| WEST VIRGINIA | | U.S.A. | | | | Washington | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Leitersburg Pike | | ROUTE #5 | | FARM WORKER | | FARMING | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| MARYLAND | | WASHINGTON | | HAGERSTOWN | | | | ROUTE #5 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| JOHN | | ALBERT RUCH | | SARAH JANE DALBY | | 235-03-3045 | | FRANK HARLESS CHARLESTON, WEST VIRGINIA | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Basal skull fracture and com- pound fracture of right tibia and fractured right femur | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | Sudden | | | | |
| 8147 | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| | | (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | 8129 | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR MIN 9:14 P.M. 12-10, 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) Struck by vehicle | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Leitersburg Pike | | 21f. LOCATION Street or R.F.D. No. City or Town County State Washington, Md. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspections <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22b. DATE SIGNED 12/11/68 | | 22c. REGISTRAR'S SIGNATURE Charles Judge | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | Howard N. Weeks, Hagerstown | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) | | Washington | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | 12/13/68 | | SPRING HILL CEMETERY | | CHARLESTON W. VA. | | | | |
| 24. FUNERAL DIRECTOR | | HAGERSTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Charles R. Ruzer | | | | DEC 16 1968 | | | | | | |

81031

00121

8301 11030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1/68

| 184101 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18414 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | A. M. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Walter George Ryan | | | | | | | | | | 2a. DATE OF DEATH December 23, 1968 | | | | | | | | | | 2b. HOUR A. M. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX Male | | | | | | | | | | 4. RACE White | | | | | | | | | | 5. DATE OF BIRTH March 5, 1893 | | | | | | | | | | 6. AGE (In years last birthday) 75 YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Ohio | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH Washington Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Williamsport | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2733 Virginia Ave. | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Inspector-Fairchild Retired | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | | | | | | | 13b. COUNTY Washington Wmsport | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER 2733 Virginia Ave. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last No Record | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last No Record | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | | | | | | | | | 16b. SOCIAL SECURITY NO. 214-09-7398 | | | | | | | | | | 17. INFORMANT William Burhams Jr. Hagerstown Md. 230 Potomac Hgts. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4109 Acute coronary occlusion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) Arteriosclerotic heart disease | | | | | | | | | | | | | | | | | | | | yrs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4201 Gouty arthritis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION none | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. none 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) none | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) none | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug, 1961, to Dec, 1968, that (I) (we) last saw the deceased alive on Dec 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Harold R. Tritch Jr MD | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 12/24/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Harold R. Tritch Jr MD | | | | | | | | | | 22e. ADDRESS 302 N. Potomac St Hagerstown, Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE 12/26/68 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) Hagerstown Wash. Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Hagerstown, Maryland Andrew K. Coffman Funeral Home Inc. | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 27 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

18412

December 23, 1953

Walter

George

White

75

March 5, 1953

White

Ohio

Washington

U.S.A.

Ohio

Inspector-Philadelphia Retired

2733 Virginia Ave.

Williamsport

2733 Virginia Ave.

Washington

Maryland

No Record

No Record

no

214-02-7098 William Williams Jr.

Washington

Burial 12/5/53 West Haven Cemetery Hagerstown Wash. D.C.

Andrew A. Coffman Funeral Home Inc. Hagerstown, Maryland

DEC 24 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18402 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18415 | | | |
|---|--|--|---|--|--|---|---|--|---|---|---|---|--|---------------------------|----------------|--------------------------|--|--------------|--|------------------|--|-------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Henry | | | Middle Bushrod | | | Last Sampsell | | | 2a. DATE OF DEATH Month December | | | | Day 5 | | Year 1968 | | 3b. HOUR 8:00 | | A. M. | |
| 3. SEX male | | | 4. RACE white | | | 5. DATE OF BIRTH 10-28-1883 | | | | 6. AGE (In years last birthday) 85 YRS. | | | | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS. DAYS | | HOURS | | MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH Washington Md. | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Avalon Manor | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Motor Man | | | | 12b. KIND OF BUSINESS OR INDUSTRY Utilities | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Wash. | | | 13c. CITY OR TOWN Hagerstown | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 1005 Pope, Ave. | | | | | | | | | | | | |
| 14. FATHER'S NAME First William B. | | | Middle Sampsell | | | Last Sampsell | | | 15. MOTHER'S MAIDEN NAME First Nannie | | | Middle Fuller | | | Last Fuller | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 217-10-9364 | | | 17. INFORMANT Address Mrs. John Pangborn Hagerstown, Md. | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis due to</u> <u>4339</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Longstanding Diabetes</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Nov 24-68</u> <u>Many years</u> | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <u>332 X Arterio-sclerosis Heart Disease</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | | County | | | State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 2, 1967</u> , to <u>Dec 5, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 5, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Sidney Novenstein MD</u> | | | 22c. DATE SIGNED 12-5-68 | | | 22d. PHYSICIAN'S NAME (Type) FUNK STOWN MD | | | 22e. ADDRESS SIDNEY NOVENSTEIN | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 12-7-1968 | | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | | 23d. LOCATION (City or Town) Hagerstown, Md. | | | (County) | | | (State) | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md. | | | 25a. REC'D BY REGISTRAR DATE DEC 9 1968 | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | | | | | | | | | |

October 10, 1941

Dear Sir,

Enclosed

Very

10-22-1941

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1968

| 184193 | | | | | | | | | | 18416 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | |
| Joseph Hand Scranton, Jr. | | | | | | | | | | December 30 1968 | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | |
| Male | | | | | | | | | | White | | | | | | | | | |
| 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years lost birthday) | | | | | | | | | |
| August 17, 1908 | | | | | | | | | | 60 YRS. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | |
| Vergennes, Vermont | | | | | | | | | | USA | | | | | | | | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | |
| | | | | | | | | | | Washington Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | |
| Hagerstown | | | | | | | | | | Washington Co. Hospital | | | | | | | | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Locomotive Engineer | | | | | | | | | | Railroad | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | |
| Maryland | | | | | | | | | | Washington | | | | | | | | | |
| 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| Hagerstown | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| | | | | | | | | | | 1141 Fairview Road | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | |
| Joseph Hand Scranton, Sr. | | | | | | | | | | Leona Farmer | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | |
| No | | | | | | | | | | 232-01-8275 | | | | | | | | | |
| 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | |
| Mrs. Elizabeth Scranton | | | | | | | | | | 1141 Fairview Rd. Hagerstown, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute nephritis | | | | | | | | | | 48 hours | | | | | | | | | |
| 4120 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) Hypertensive athrosclerotic cardio-renal disease. | | | | | | | | | |
| | | | | | | | | | | Sev. yrs. | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | | | | | |
| 442X | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | |
| 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1955, to 12/30, 1968, that (I) (we) last saw the deceased alive on 12/30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | |
| Howard N. Weeks, M. D. | | | | | | | | | | 1/2/69 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | |
| Howard N. Weeks, M. D. | | | | | | | | | | 580 Northern Ave., Hagerstown, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | |
| Burial | | | | | | | | | | 1/2/69 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| Rest Haven Cemetery | | | | | | | | | | Hagerstown-Washington-Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | |
| Charles C. Host | | | | | | | | | | DATE JAN 6 1969 | | | | | | | | | |
| Rest Haven Funeral Chapel Hagerstown, Md. | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| | | | | | | | | | | Charles Judge | | | | | | | | | |

MEDICAL CERTIFICATION

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| 184104 | | | | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 18417 | | | | | |
|--|--|--|--|---|---|---|---|---|--------------------------------|--|--------------------------------|---|--|
| 1. DECEASED-NAME (Type or print) | | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | | 2b. HOUR M | | |
| Millard | | | | Filmore | | Shank | Dec. 9 1968 | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH April 14, 1877 | | | 6. AGE (In years lost birthday) 91 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Shanktown, Md | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Big Spring, Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rural 1 | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Foreman retired | | | 12b. KIND OF BUSINESS OR INDUSTRY Co. Roads | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Big Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Rural 1 | | | | | |
| 14. FATHER'S NAME Jacob | | First Middle Last # Shank | | 15. MOTHER'S MAIDEN NAME Angeline | | First Middle Last # Eddy | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT Miss Marion Shank | | Address Big Spring, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart Disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>advanced generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis obliterans</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4200? Arteriosclerotic hypertension, benign</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 yrs</u> <u>30 yrs</u> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 23</u> , 19 <u>68</u> , to <u>Dec 9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct 5</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Edward W. Ditto</u> | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 12-10-68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Edward W. Ditto M.D. 111 | | 22e. ADDRESS 217 W. Washington St. Hagerstown, Maryland | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Dec. 12, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cem. | | 23d. LOCATION (City or Town) (County) (State) Western Pike Wash. Md. | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Marquet Rowland</u> | | ADDRESS Clear Spring, Md. | | 25a. REC'D BY REGISTRAR DATE DEC 16 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | |

VA (15-4)
30M REV 1/68

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|--|--|--|------------------------------|---|--|---|---------------------------------|--|--------------------|------------------------|-----------------------------------|-----|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| Arthur Clyde Shifler | | | | | | December 14, 1968 | | | 4:10A M | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Male | | White | | March 26, 1884 | | | 84 YRS. | | MONTHS 8 DAYS 18 | | HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| Monroe, Md. | | | U. S. A. | | | | | | Washington | | | Md. | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | | | Avalon Manor Nursing Home | | | | Farmer | | | Farming | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | | | Washington | | Boonsboro | | | | 50 St. Paul St. | | | |
| 14. FATHER'S NAME | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | | | | |
| Otho Shifler | | | | | | Arbelia Doub | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | |
| No. | | | | 216-14-6245 | | Mrs. Gussie E. Shifler, Boonsboro, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Stomach</u> 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos 3 days | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 151X | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 10, 1968, to Dec 14, 1968, that (I) (we) last saw the deceased alive on Dec 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | G. W. LeVan M.D. | | DEGREE ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. | | 22c. DATE SIGNED 12-14, 68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | G. W. LeVan M.D. | | 22e. ADDRESS | | Boonsboro Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | |
| Burial | | 12- 17- 68 | | Boonsboro Cemetery | | Boonsboro, Wash. Co., Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| John H. Bast, Jr. | | | | 112 N. Main St. Boonsboro, Md. | | DEC 18 1968 | | J. Charles Judge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--|---|--|---|--|
| 18406 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 18419 | |
| Item 6 Film 408 1/6/69 kk | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED-NAME (Type or print) Edward | | First E Middle Shipe Last | | 2a. DATE OF DEATH Month December Day 27 Year 1968 | |
| 3. SEX Male | | 4. RACE White | | 2b. HOUR 3:40 PM | |
| 5. DATE OF BIRTH August 18, 1875 | | 6. AGE (In years last birthday) 93 92 YRS. | | IF UNDER 1 YEAR MONTHS 00 DAYS 00 HOURS 00 MIN. | |
| 7a. BIRTHPLACE (State or foreign country) W. Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9. COUNTY OF DEATH WASHINGTON | | Md. | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter | |
| 12b. KIND OF BUSINESS OR INDUSTRY -- | | 13a. STREET AND NUMBER 145 So Locust St | | | |
| 13b. COUNTY Maryland | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Luther Middle Shipe Last | | 15. MOTHER'S MAIDEN NAME First Lana Middle Shipe Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO. 123-07-7833 | | 17. INFORMANT Address Mrs Belle Clark 145 So Locust St Hagerstown | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 433.9 IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) unknown | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 days | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 332x | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/28 , 19 67 , to 12/27 , 19 68 , that (I) (we) lost saw the deceased alive on December 27, 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Domingo A. Garcia | | DEGREE ATTENDING <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 12/27/68 | |
| 22d. PHYSICIAN'S NAME (Type) Domingo A. Garcia, M.D. | | 22e. ADDRESS Western Maryland State Hospital Hagerstown, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12/30/68 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery Hagerstown Wash Co Md | |
| 23d. LOCATION (City or Town) (County) (State) Hagerstown Md | | 24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc | | 25a. REC'D BY REGISTRAR DEC 31 1968 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

VR 1514
REV 1/68

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 18407 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 18420 | |
| 1. DECEASED-NAME (Type or print) | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Harold William Sigler | | | | December 27, 1968 | | 9:00A M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | |
| Male | | White | | Jan. 16, 1908 | | 60 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Middletown, Md. | | U. S. A. | | Washington | | Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Boonsboro | | Rfd. 2 | | Maintenance | | Aircraft | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Maryland | | Washington | | Boonsboro | | Rfd. 2 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | |
| John | | Lucy | | No. | | 214-10-4334 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 60212 | | 19. ADDRESS | |
| Mrs. Francis R. Sigler, Rfd. 2, Boonsboro, Md. | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2 P.M., 1968, to 1:00 P.M., 1968, that (I) (we) last saw the deceased alive on 12 Nov 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>Elmer Stochlender</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 12/25/68 | | 22d. ADDRESS <u>Hagerstown Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | 12- 29- 68 | | Boonsboro Cemetery | | Boonsboro, Wash. Co., Md. | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | DATE | |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | DEC 31 1968 | | Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | |
|--|------------------------------|--|--|---|--|--|----------|--|
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | |
| Edwin Bruce Smith | | | | | December 27, 1968 | | M | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| male | white | | Sept. 19, 1893 | | 75 YRS. | MONTHS DAYS | | HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | USA | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | Wash. Co. Hospital | | crane operator | | Railroad | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | | |
| Md. | | Wash. | | Hagerstown | | 523 Jefferson St. | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | First Middle Last | | | | | | |
| William Smith | | Fannie Boward | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| no | | 705-10-5441 | | Ellen Smith, Hagerstown, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) Peritonitis and ilius | | | | | | | | 1 WKS |
| 567.9 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 576x | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| Pneumonia, coronary artery disease, emphysema | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12/25/1968, to 12/27/1968, that (I) (we) last saw the deceased alive on 12/27/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | |
| Howard N. Weeks | | 12/28/68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | |
| Howard N. Weeks | | 580 Northern Ave., Hagerstown Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 12-30-68 | | Rose Hill Cemetery | | Hagerstown, Md. | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Minnich Funeral Home, Hagerstown, Md. | | | | DATE DEC 31 1968 | | Charles Judge | | |

1893

STATE OF OHIO

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County of _____

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>18409</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>18422</div> | | | | | | | | | |
|---|--|--|---|--|--|--|--|---|---|
| 1. DECEASED-NAME (Type or print) EMMA First Middle Last | | | | | 2a. DATE OF DEATH DECEMBER Month 15 Day 68 Year | | | 2b. HOUR 12.40 | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH FEBRUARY 26, 1878 | | | 6. AGE (In years lost birthday) 90 YRS. | | IF UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON Md. | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AVALEN MANOR NURSING HOME | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY WASHINGTON | | 13c. CITY OR TOWN HAGERSTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 227 N. MULBERRY ST. |
| 14. FATHER'S NAME First Middle Last JEROME | | | 15. MOTHER'S MAIDEN NAME First Middle Last BRITNER | | | 15. MOTHER'S MAIDEN NAME First Middle Last CAROLYN UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 213-10-6892 B | | 17. INFORMANT MR. CLAUDE SMITH 227 Address N MULBERRY ST. HAGERSTOWN, MARYLAND | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident , 4120 DUE TO, OR AS A CONSEQUENCE OF Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 443X (b) _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Urinary Tract Infection. Hemorrhage from G.I. Tract (Nov 68) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Nov 18 , 19 68 , to Dec 15 , 19 68 , that (I) (we) last saw the deceased alive on Dec 14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE W. T. Layman DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 12/16/68 | | | |
| 22b. PHYSICIAN'S NAME (Type) WILLIAM T. LAYMAN, M.D. | | | | | | 22e. ADDRESS 301 E ANTIETAM ST., HAGERSTOWN, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 12/18/68 | | 23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASHINGTON, MD. | | | |
| 24. FUNERAL DIRECTOR Charles M. Ronger ADDRESS HAGERSTOWN, MARYLAND | | | | 25a. REC'D BY REGISTRAR DEC 20 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>18410</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>18423</div> | | | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) ^{First} GLENDORA ^{Middle} GERTRUDE ^{Last} SNYDER | | | | | | 2a. DATE OF DEATH ^{Month} DECEMBER ^{Day} 8 ^{Year} 1968 | | 2b. HOUR 4A. M | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH 10/9/1890 | | 6. AGE (In years last birthday) 78 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON Md. | | | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. COUNTY HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY WASHINGTON | | 13c. CITY OR TOWN HAGERSTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 801 OAK HILL AVE. | | | |
| 14. FATHER'S NAME ^{First} CHARLES ^{Middle} D. ^{Last} WAGAMAN | | | | 15. MOTHER'S MAIDEN NAME ^{First} LULA ^{Middle} ^{Last} LANTZ | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 216-22-7739B | | 17. INFORMANT HAGERSTOWN MD. MR. JOHN S. SNYDER | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4339 Bilateral lobular pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral thrombosis + complete DUE TO, OR AS A CONSEQUENCE OF (c) rt. hemiplegia | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 days 8 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332x | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 29, 1968, to Dec 8, 1968, that (I) (we) last saw the deceased alive on Dec 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Edward W. Ditto, III, M.D. DEGREE ATTENDING PHYS. | | | | | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 12-9-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Edward W. Ditto, III, M.D. | | | | | | 22e. ADDRESS 217 W. Washington Street Hagerstown, Maryland | | | | | |
| 23a. BURIAL, CREMATION, or other disposal of body BURIAL | | 23b. DATE 12/10/68 | | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM. | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD. | | | | | |
| 24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md. | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 13 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18411

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18424

| | | | | | | | | | |
|---|-------------------------|--|--|---|---|---|---|---|--|
| 1. DECEASED-NAME (Type or Print) First Middle Last Ralph Waldo Snyder | | | 2a. DATE KNOWN OF DEATH Month Day Year 12 18 1968 | | | 2b. HOUR 11:22 PM | | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH July 17, 1901 | 6. AGE (in years last birthday) 67 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS HOURS MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year 12 18 1968 | | | 2d. HOUR 11:52 PM |
| 7a. BIRTHPLACE (State or foreign country) Hagerstown, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk | | | 12b. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 424 W. Franklin St. |
| 14. FATHER'S NAME First Middle Last Robert Bruce Snyder, Sr. | | | 15. MOTHER'S MAIDEN NAME First Middle Last Mae Mahala Bowen | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | |
| 16b. SOCIAL SECURITY NO. 213-18-8661A | | | 17. INFORMANT ADDRESS Williamsport, Md. Robert B. Snyder 112 Williams Circle | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary atherosclerosis - circumflex Ar. DUE TO, OR AS A CONSEQUENCE OF (b) St. Coronary due DUE TO, OR AS A CONSEQUENCE OF (c) Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 - 1 hr. 15-20 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Pulmonary Emphysema, Benign nephrosclerosis, Prostate hypertrophy | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE Edward W. Ditto, III, M.D. | | | M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED 12-19-68 | |
| EXAMINER'S NAME (Type) | | | ADDRESS | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) 217 W. Washington St. Hagerstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12/24/68 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington-Md. | | | |
| 24. FUNERAL DIRECTOR Wm. C. Hest | | | ADDRESS Rest Haven Funeral Chapel Hagerstown, Md. | | | 25a. REC'D BY REGISTRAR DATE DEC 23 1968 | | 25b. REGISTRAR'S SIGNATURE Chambers Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

18425

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last Alice Marguerite Spangler | | | 2a. DATE OF DEATH Month Day Year December 3, 1968 | | 2b. HOUR 8:58 A.M. |
| 3. SEX female | 4. RACE white | 5. DATE OF BIRTH May 5, 1889 | | 6. AGE (In years last birthday) 79 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Penna. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Washington Md. | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna. | 13b. COUNTY Fulton | 13c. CITY OR TOWN McConnellsburg | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First Middle Last George W. Hays | | 15. MOTHER'S MAIDEN NAME First Middle Last Virginia Michaels | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no | | 16b. SOCIAL SECURITY NO. none | 17. INFORMANT Address Mrs. Mary E. Helleman, McConnellsburg Penna. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/17, 1968, to 12/3, 1968, that (I) (we) last saw the deceased alive on 12/2/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Edson B. Moody | | 22c. DATE SIGNED 12/4/68 | | 22d. PHYSICIAN'S NAME (Type) Edson B. Moody | |
| 22e. ADDRESS 363 Cleveland Ave., Hag., Md. | | 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE 12-5-68 | | 23c. NAME OF CEMETERY OR CREMATORY Union Cemetery | |
| 23d. LOCATION (City or Town) (County) (State) McConnellsburg, Penna. | | 23e. REC'D BY REGISTRAR DEC 9 1968 | | | |
| 23f. REGISTRAR'S SIGNATURE Charles Judge | | 23g. ADDRESS Kelso Funeral Home, McConnellsburg, Pa | | | |

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White Mountains, New Hampshire

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Mr. and Mrs. E. J. Johnston, Johnston, New Hampshire

London

no

323 Riverside Ave., New York

Edson B. 1950

Johnston Cemetery

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Johnston Cemetery, Johnston, New Hampshire

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18413

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| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. DECEASED-NAME (Type or print) LORENA | | First C. Middle STEIGER Last | | 2a. DATE OF DEATH Dec. 12, 1968 | | 2b. HOUR A.M. 3:30 | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Apr. 16, 1899 | | 6. AGE (In years last birthday) 69 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Franklin Co. Pa. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | |
| 10. CITY OR TOWN OF DEATH Hagerstown, R.D. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Avalon Manor | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Store clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Apparel | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 13e. STREET AND NUMBER 112 S. Prospect | | 14. FATHER'S NAME George S. Cover | | 15. MOTHER'S MAIDEN NAME Mary Catherine Narcleroad | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No | | 16b. SOCIAL SECURITY NO. 203-10-6498 | | 17. INFORMANT Ralph D. Myers | | 17b. ADDRESS 4611 Guilford Rd. College Park, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma, abdominal 1538 DUE TO, OR AS A CONSEQUENCE OF (b) probably from colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? 6 mo - |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1538 Exploratory laparotomy 10/4/68 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-17, 1968 , to 12-12, 1968 , that (I) (we) last saw the deceased alive on 11/21/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John H. Hornbaker M.D. | | | | 22c. DATE SIGNED 12-13-1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) JOHN H. HORNBAKER, M.D. | | | | 22e. ADDRESS 154 West Washington St., Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12/15/68 | | 23c. NAME OF CEMETERY OR CREMATORY Fairview Cem. | | 23d. LOCATION (City or Town) (County) (State) Mercersburg Franklin Pa. | |
| 24. FUNERAL DIRECTOR J.H. Swinger, Mercersburg, Pa. | | | | 25a. REC'D BY REGISTRAR DATE DEC 17 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED-NAME (Type or print) ELIZABETH YOCOM STICKNEY | | | 2a. DATE OF DEATH Month 11 Day 68 Year 9 aM | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH DECEMBER 11, 1902 | |
| 7a. BIRTHPLACE (State or foreign country) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH WASHINGTON Md. | | | 6. AGE (In years last birthday) 66 YRS. | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1704 CREST DRIVE | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SECRETARY | |
| 12b. KIND OF BUSINESS OR INDUSTRY GAS COMPANY | | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY WASHINGTON | |
| 13c. CITY OR TOWN HAGERSTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 1704 CREST DRIVE | |
| 14. FATHER'S NAME First Middle Last WILLIAM HOWARD MERSEREAU | | | 15. MOTHER'S MAIDEN NAME First Middle Last ELIZABETH YOCOM | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 136-26-8291 | | 17. INFORMANT 1704 Address CREST DR. MRS. WARREN JOHNSON HAGERSTOWN, MARYLAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) subarachnoid Hemorrhage 4309 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Vasc. Disease DUE TO, OR AS A CONSEQUENCE OF (c) ? APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 min. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 330x | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 8, 1963 , to Dec 11, 1968 , that (I) (we) last saw the deceased alive on Dec 11, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Lloyd A. Hoffman DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED 12/12/68 | |
| 22d. PHYSICIAN'S NAME (Type) LLOYD A. HOFFMAN, M.D. | | | | 22e. ADDRESS 214 N POTOMAC ST., HAGERSTOWN, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION | | 23b. DATE 12/14/68 | | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CREMATORY | |
| 23d. LOCATION (City or Town) (County) (State) LINDEN UNION NEW J. | | 24. FUNERAL DIRECTOR Charles M. Langer ADDRESS HAGERSTOWN, MARYLAND | | | |
| 25a. REC'D BY REGISTRAR DEC 16 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

1800

DEC 1 1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 1-64
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

18415

18428

| | | | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|---|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last Karl Oliver Stoner | | | 2a. DATE OF DEATH Month Day Year December 20 1968 | | | 2b. HOUR M | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH July 1, 1909 | | 6. AGE (In years last birthday) 59 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Hagerstown, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 21 S. Potomac St. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sheet Metal | | | 12b. KIND OF BUSINESS OR INDUSTRY Aircraft | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 21 S. Potomac St. | | |
| 14. FATHER'S NAME First Middle Last Arthur Jacob Stoner | | | 15. MOTHER'S MAIDEN NAME First Middle Last Annie Agnes Keedy | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No | | | 16b. SOCIAL SECURITY NO. 214-09-2343 | | 17. INFORMANT Address Mrs. K.O. Stoner 21 S. Potomac St. Hagerstown, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia (probable) 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4200 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan, 1968 , to Dec, 1968 , that (I) (we) last saw the deceased alive on Dec 19, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Charles C. Spencer DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 12-23-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Charles C. Spencer | | | | | | 22e. ADDRESS 220 145 S. Prospect St. Hagerstown Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 12/23/68 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington-Md | | | |
| 24. FUNERAL DIRECTOR Wm. C. Host Rest Haven Funeral Chapel | | | | | | ADDRESS Hagerstown, Md. | | 25a. REC'D BY REGISTRAR DATE DEC 27 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

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DEC 21 1968

Handwritten signature

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

184116

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18429

| | | | | | | | | | | | | | | | | | |
|--|--|------------------|---|--|--|--|--|---|---|---|--|--|--|--|------------------------------|--|--|
| 1. DECEASED-NAME (Type or Print) First JOHN Middle EDWARD Last STONESIFER | | | 20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 12 Day 31 Year 1968 | | | 2b. HOUR M | | | | | | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 1-14-1906 | | 6. AGE (In years last birthday) 62 YRS. | | 7c. DATE PRONOUNCED DEAD Month December Day 31 Year 1968 | | 2d. HOUR M | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Carroll Co | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Washington Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Trackman | | | 12b. KIND OF BUSINESS OR INDUSTRY W.M. RR | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Carroll | | | 13c. CITY OR TOWN Taneytown | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER R.D.2 | | | | | |
| 14. FATHER'S NAME First John A. Last Stonesifer | | | 15. MOTHER'S MAIDEN NAME First Minnie Last Fleagle | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No | | | 16b. SOCIAL SECURITY NO. 705-10-5297 | | | 17. INFORMANT Elenora K. Stonesifer | | | ADDRESS Taneytown Md. RD2 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>myocardial infarction</u> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Howard N. Weeks | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | 22b. DATE SIGNED 1/1/69 | | | | | |
| EXAMINER'S NAME (Type) Howard N. Weeks | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | |
| | | | | | | ADDRESS (Street, city, town, or county) WASHINGTON COUNTY | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE 1-3-69 | | 23c. NAME OF CEMETERY OR CREMATORY Keesville, Cemetery | | | | 23d. LOCATION (City or Town) (County) (State) Keesville, Maryland. | | | | | | | |
| 24. FUNERAL DIRECTOR Raymond E. Creager | | | | | | ADDRESS Thurmont, Md. | | | | 25a. REC'D BY REGISTRAR JAN 6 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

18422

JOHN EDWARD STONE

December 21, 1938

Male White 1-1-1

notified

Washington Co. Hospital

R.O.S.

January

Control

Medical

U.S. Army, Medical Department, Washington, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

18430

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|--------------------------------|--|--|
| 1. DECEASED NAME (Type or print) Ralph | | | First J Middle Stottlemeyer Last | | | 2a. DATE OF DEATH Month Dec. Day 12 Year 1968 | | | 2b. HOUR M | | | | | | | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH Jan 24 1897 | | | 6. AGE (In years last birthday) 71 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Indiana | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Washington Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Washington | | | 13c. CITY OR TOWN Hagerstown | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 808 Washington Ave. | | | | | |
| 14. FATHER'S NAME First Rufus Middle Stottlemeyer Last | | | 15. MOTHER'S MAIDEN NAME First Pearl Middle Wetghet Last | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 216-22-2021 | | | 17. INFORMANT 808 Washington Ave. Mrs. Kenneth Dennis Hagerstown Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Agnogenic Myeloid sclerosis 2895 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2987 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mo. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Leomyosarcoma - small bowel | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION Dec. 7th | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Splenomegaly | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July , 19 64 , to Dec. 12 , 19 68 , that (I) (we) last saw the deceased alive on Dec 12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Lloyd A. Hoffman DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | 22c. DATE SIGNED 12/13/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman | | | | | | | | | | | | 22e. ADDRESS 214 N. Potomac St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE Dec. 15-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Williamsport Wash. Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR Mr. Albert L. Leaf Williamsport Md. | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 16 1968 | | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | | |
|--|--|--|--|--|-------------|--|--|--|--|
| 18418 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 18431 | | | |
| 1. DECEASED-NAME (Type or print) | | First George | | Middle W. | Last Strain | 2a. DATE OF DEATH | | 2b. HOUR | |
| | | | | | | Month Dec. Day 9 Year 1968 | | M | |
| 3. SEX | | Male | | 4. RACE | | Colored | | 5. DATE OF BIRTH | |
| | | | | | | March 14 1893 | | 6. AGE (In years last birthday) | |
| | | | | | | 75 YRS. | | IF UNDER 1 YEAR MONTHS 8 DAYS 25 | |
| 7a. BIRTHPLACE (State or foreign country) | | North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? | | U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| | | | | | | | | 9. COUNTY OF DEATH | |
| | | | | | | | | Washington Md. | |
| 10. CITY OR TOWN OF DEATH | | Williamsport Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 43 E. Church St. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | |
| | | | | | | | | Laborer | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | Brick Yard | | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | Maryland | | 13b. COUNTY | |
| | | | | | | Washington | | 13c. CITY OR TOWN | |
| | | | | | | Williamsport | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | | 13e. STREET AND NUMBER | |
| | | | | | | | | 43 E. Church St. | |
| 14. FATHER'S NAME | | First Unknown | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | |
| | | | | | | | | First Unknown | |
| | | | | | | | | Middle | |
| | | | | | | | | Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) | | Yes | | 16b. SOCIAL SECURITY NO. | | 216-07-6993 | | 17. INFORMANT | |
| | | | | | | | | 43 E Church St. Mrs. Arlene Strain Williamsport, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) Myocardial infarction | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 10 mins ± | |
| | | | | 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | 10 yrs | |
| | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) Atherosclerosis | | | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | | | (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | 4201 | | none | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (the physician) attended the deceased from Aug. 19, 1958, to Nov. 8, 1968, that (I) (we) last saw the deceased alive on Dec. 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | M. E. Byrkit | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | Dec. 9, 1968 | |
| | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | M. E. Byrkit, M. D. | | 22e. ADDRESS | | Williamsport, Maryland 21795 | | | |
| | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Dec. 12-68 | | Riverview Cemetery | | Williamsport Wash. Md. | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Albert L. Leaf | | Williamsport Md. | | DATE DEC 12 1968 | | J. Charles Judge | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------|------------------------------|--|--|--|---|---|--------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| William Zabeau Sullivan | | | | | | Month Day Year | | 12 17 1968 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | |
| Male | White | Jan 21 1930 | 38 YRS. | MONTHS | DAYS | HOURS | MIN. | Month Day Year | 12 17 1968 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Sisterville | | U.S.A. | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Hagerstown | | | Washington County Hospital | | | Pharmacist | | | Drug Store |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | | | |
| Maryland | | | Washington | Williamsport | | 136 E. Potomac St. | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Michael J Sullivan | | | Berthe M Zabeau | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| No | | | 188-22-0286 | | Mrs. Sue Ann Sullivan Williamsport, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X DUE TO, OR AS A CONSEQUENCE OF Acute lobar pneumonia involving both lungs (b) DUE TO, OR AS A CONSEQUENCE OF (c) 17 PULMONARY | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 490X | | | | | | | | | Approx. 4-6 days |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER | | | 217 W. Washington St. Hagerstown, Md. | | | |
| Edward W. Ditto, III, M.D. | | | DEPUTY MEDICAL EXAMINER | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | Dec. 20-68 | | Greenlawn Cemetery | | Williamsport Wash. Md. | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| Albert L. Leaf Williamsport, Md. | | | | | | | DEC 23 1968 | | |

18683

OF THE
NORTH OCEAN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 1. DECEASED-NAME (Type or print) First Middle Last | | | | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR M | |
|--|--|---|--|---|--|--|--|
| NETTIE ARBELLA SWOPE | | | | DECEMBER 14 | | 68 Year | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH OCTOBER 6, 1893 | | 6. AGE (In years last birthday) 75 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON Md. | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY HOSP. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY WASHINGTON | | 13c. CITY OR TOWN HAGERSTOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER 848 MARSHALL ST. | | 14. FATHER'S NAME First Middle Last SAMUEL OLIVER SPESSARD | | 15. MOTHER'S MAIDEN NAME First Middle Last EMMA SHANK | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT 848 Address MARSHALL ST. MR. CHARLES V SWOPE HAGERSTOWN, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of liver & local spread.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1561</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Juvenile (obstructive).</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>23 Jan 1968</u> , to <u>14 Dec 1968</u> , that (I) (we) last saw the deceased alive on <u>13 Dec 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Richard T Binford</u> | | | | 22c. DATE SIGNED 12/16/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) RICHARD T BINFORD, M.D. | | | | 22e. ADDRESS 1135 POTOMAC AVE., HAGERSTOWN, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 12/17/68 | | 23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASHINGTON, MD. | |
| 24. FUNERAL DIRECTOR <u>Charles M. Louger</u> | | | | 25a. REC'D BY REGISTRAR DATE DEC 20 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

1-1-13

DEC 10 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|---|--|
| 1. DECEASED-NAME (Type or print) LUCIAN TERRY THOMAS | | | 2a. DATE OF DEATH Month 3 Day 68 Year 1898 | | | 2b. HOUR 4:30am | | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH AUGUST 31, 1898 | | 6. AGE (In years last birthday) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON Md. | | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED SALEMAN | | | 12b. KIND OF BUSINESS OR INDUSTRY PLUMBING SUPPLIES | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY WASHINGTON | | 13c. CITY OR TOWN HAGERSTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 831 WOODLAND DR | |
| 14. FATHER'S NAME First Middle Last WILBUR THOMAS | | | 15. MOTHER'S MAIDEN NAME First Middle Last BLANCHE MITCHELL | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 229-10-3741 | | 17. INFORMANT MRS GLADYS THOMAS | | | 831 Address WOODLAND HAGERSTOWN, MARYLAND | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days year | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes mellitus & diabetic acidosis | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Nov. 30, 1968 to Dec. 13, 1968 , that (I) (we) last saw the deceased alive on December 2, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Edson B. Moody | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 12/3/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) EDSON B MOODY, M.D. | | 22e. ADDRESS 363 CLEVELAND AVE., HAGERSTOWN, MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 12/5/68 | | 23c. NAME OF CEMETERY OR CREMATORY RIVERVIEW CEMETERY | | 23d. LOCATION (City or Town) (County) (State) RICHMOND VIRGINIA | | | | |
| 24. FUNERAL DIRECTOR Charles M. Rougar | | ADDRESS HAGERSTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR DEC 6 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |

13221

PLATE 100-1079

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DEC 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) CLYDE OLIVER TRUMPOWER, SR. | | | | | | 2a. DATE OF DEATH Month Dec. Day 14 Year 1968 | | | 2b. HOUR M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH May 1, 1888 | | | 6. AGE (In years last birthday) 80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. County Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist | | | 12b. KIND OF BUSINESS OR INDUSTRY retired | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Washington | | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Sharpsburg Pike | |
| 14. FATHER'S NAME First Joseph Middle Last Trumpower | | | | 15. MOTHER'S MAIDEN NAME First Catherine Middle - Last Atherton | | | | Address Hagerstown, Md. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service) -- | | | | 16b. SOCIAL SECURITY NO. 220-10-3719 | | 17. INFORMANT Edward Trumpower, 23 Lehigh Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4339 IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 4 yrs | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 332x | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day 19 Year P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. 12/12 67 | | City or Town 68 | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/12 , 19 67 , to 12/14 , 19 68 , that (I) (we) last saw the deceased alive on 12/14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we we) (did did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Donald E. Martin, M.D. DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 12/16/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D. | | | | | | 22e. ADDRESS 363 S. Cleveland Ave., Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12/17/68 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 23d. LOCATION (City or Town) Hagerstown, Wash. | | (County) | | (State) Md. | |
| 24. FUNERAL DIRECTOR Hagerstown, Md. Andrew K. Coffman Funeral Home, Inc. | | | | | | 25a. REC'D BY REGISTRAR DEC 17 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

[illegible]

| | | |
|-----------|--------------------|--------------------|
| 100-1-311 | Trueman, Catherine | Trueman, Catherine |
| 100-1-311 | Trueman, Catherine | Trueman, Catherine |

May 1, 1958

CLYDE W. OLIVER, JR., ATTORNEY AT LAW, 1000 15th St., N.W., Washington, D.C. 20004

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pen in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18436

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18436

| | | | | | | | | |
|--|-------------------------|---|--|---|------------------------------|--|--|--|
| 1. DECEASED NAME (Type or Print) Ernest # Trumpower | | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year Dec. 28 1968 | | | 2b. HOUR 1:50 | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH July 18, 1912 | 6. AGE (in years last birthday) 56 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | IF UNDER 24 HRS HOURS MIN | 2c. DATE PRONOUNCED DEAD Month Day Year Dec. 28 1968 | | |
| 7a. BIRTHPLACE (State or foreign country) Wash. Co., Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | |
| 1d. CITY OR TOWN OF DEATH Clear Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) None | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY Farming | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. CITY Washington | | 13c. CITY OR TOWN Clear Spr. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER None |
| 14. FATHER'S NAME First Middle Last David # Trumpower | | | 15. MOTHER'S MAIDEN NAME First Middle Last Grace # Slayman | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | |
| 16b. SOCIAL SECURITY NO. 215-36-7220 | | | 17. INFORMANT Mildred L. Trumpower | | | ADDRESS Clear Spring Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF (b) 450x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 465x | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 2d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE Howard N. Weeks | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 12/30/68 | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) Washington | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12/31/68 | | 23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery | | 23d. LOCATION (City or Town) (County) (State) Clear Spring, Wash. Md. | | |
| 24. FUNERAL DIRECTOR Margaret Rowland | | | | ADDRESS Clear Spring, Md. | | 25a. REC'D BY REGISTRAR JAN 2 1969 | | 25b. REGISTRAR'S SIGNATURE f Charles Judge |

1. The first of the three main groups of minerals is the group of minerals which are used in the manufacture of glass, pottery, and other articles of glass and pottery.

2. The second of the three main groups of minerals is the group of minerals which are used in the manufacture of iron and steel, and other articles of iron and steel.

3. The third of the three main groups of minerals is the group of minerals which are used in the manufacture of cement, and other articles of cement.

4. The fourth of the three main groups of minerals is the group of minerals which are used in the manufacture of brick, and other articles of brick.

5. The fifth of the three main groups of minerals is the group of minerals which are used in the manufacture of lime, and other articles of lime.

6. The sixth of the three main groups of minerals is the group of minerals which are used in the manufacture of plaster, and other articles of plaster.

7. The seventh of the three main groups of minerals is the group of minerals which are used in the manufacture of paint, and other articles of paint.

8. The eighth of the three main groups of minerals is the group of minerals which are used in the manufacture of paper, and other articles of paper.

9. The ninth of the three main groups of minerals is the group of minerals which are used in the manufacture of soap, and other articles of soap.

10. The tenth of the three main groups of minerals is the group of minerals which are used in the manufacture of sugar, and other articles of sugar.

11. The eleventh of the three main groups of minerals is the group of minerals which are used in the manufacture of alcohol, and other articles of alcohol.

12. The twelfth of the three main groups of minerals is the group of minerals which are used in the manufacture of vinegar, and other articles of vinegar.

13. The thirteenth of the three main groups of minerals is the group of minerals which are used in the manufacture of oil, and other articles of oil.

14. The fourteenth of the three main groups of minerals is the group of minerals which are used in the manufacture of gas, and other articles of gas.

15. The fifteenth of the three main groups of minerals is the group of minerals which are used in the manufacture of electricity, and other articles of electricity.

16. The sixteenth of the three main groups of minerals is the group of minerals which are used in the manufacture of heat, and other articles of heat.

17. The seventeenth of the three main groups of minerals is the group of minerals which are used in the manufacture of light, and other articles of light.

18. The eighteenth of the three main groups of minerals is the group of minerals which are used in the manufacture of sound, and other articles of sound.

19. The nineteenth of the three main groups of minerals is the group of minerals which are used in the manufacture of motion pictures, and other articles of motion pictures.

20. The twentieth of the three main groups of minerals is the group of minerals which are used in the manufacture of radio, and other articles of radio.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses after item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18437

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|-------------------------|------------------------|--|--|---|--|---|------|---|--|---|--|--|---------------------|--|--|----------------------------|--|--|--|--|--|
| 1. DECEASED-NAME (Type or Print) Garnett | | | First Walter | | | Middle Trumpower | | | Last | | | 2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Dec. 6, 19 68 | | | 2b. HOUR 1:45 PM | | | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH Feb. 3, 1897 | | 6. AGE (in years at birthday) 71 YRS. | | IF UNDER 1 YEAR MONTHS 10 DAYS 3 | | IF UNDER 24 HRS. HOURS 3 MIN. | | 2c. DATE PRONOUNCED DEAD Month Dec Day 6 Year 1968 | | | 2d. HOUR 3:12 PM | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH Washington Md. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Beaver Creek District Near Hagerstown, Md. | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Off Cool Hollow Road | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sheet Metal Worker | | | | 12b. KIND OF BUSINESS OR INDUSTRY Aircraft | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland | | | | 13b. COUNTY Washington | | | | 13c. CITY OR TOWN Hagerstown | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 1925 Lexington Ave. | | | | | | | | | |
| 14. FATHER'S NAME Frank | | | | | | First Trumpower | | | | | | Middle Mina | | | | | | Last Bridendolph | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | | | 16b. SOCIAL SECURITY NO. 214-09-6703 | | | | | | 17. INFORMANT Mrs. Dorothy Trumpower Hagerstown, Maryland | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease + DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4109 | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201 | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Edward W. Ditto III M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | 22b. DATE SIGNED 12-8-68 | | | | | | | | | | | |
| EXAMINER'S NAME (Type) Eward W. Ditto III Hagerstown, Md. | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE Dec. 9, 1968 | | | | 23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery | | | | 23d. LOCATION (City or Town) (County) (State) Williamsport, Wash., Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Albert L. Leaf | | | | | | ADDRESS Williamsport, Maryland. | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 12 1968 | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | |

Common Occurrence

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|------------------------------|---|---|------------------------------------|--|---|--|---|--|------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| William Woodrow Trumpower | | | | | | Month Day Year December 11 1968 | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | White | | July 28, 1914 | | | 54 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Williamsport, Md. | | USA | | | | Washington Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | | Washington Co. Hospital DOA | | | Machinist | | | Railroad | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | | Washington | | Williamsport | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | R # 1 | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | |
| James Vernon Trumpower | | | May Lula Guessford | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | | |
| No | | | 705-10-4685 | | | Mrs. W.W. Trumpower R # 1 Williamsport, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | |
| (b) <u>Arteriosclerotic heart disease</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) <u></u> | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 4201 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>12-7</u> , 19 <u>68</u> , that (I) (last) saw the deceased alive on <u>12-7-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | |
| Robert J. Keadle | | | 12-11-68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | |
| Robert J. Keadle M.D. | | | 580 Northern Ave. Hagerstown, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | 12/14/68 | | Rest Haven Cemetery | | Hagerstown-Washington-Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Wm. C. West | | | DATE DEC 16 1968 | | | f Charles Judge | | | | | | |
| Rest Haven Funeral Chapel Hagerstown, Md. | | | | | | | | | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | Stephen Michael Wagner | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Baby Boy | | Wagner | | | | Month 12 Day 24 Year 68 | | 3.40 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Male | | White | | 12-23-68 | | YRS. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | Wash. Co. Hospital | | None | | Infant | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Washington | | Camp Ritchie | | | | Bldg 462 Apt A. | |
| 14. FATHER'S NAME First Middle Last | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| John Emanuel Wagner | | Frmgard Louise Weikard | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | None | | John E. Wagner IV Bldg 462 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Respiratory Distress Syndrome | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Hyaline Membrane Disease | | | | | | | | 1 day | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| Prematurity | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 23 Dec, 19 68, to 24 Dec, 19 68, that (I) (we) last saw the deceased alive on 24 Dec, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Ronald E. Keyser M.D. | | | | | | | | 22c. DATE SIGNED 24 Dec 68 | |
| 22d. PHYSICIAN'S NAME (Type) Ronald E. Keyser | | | | 22e. ADDRESS 119 King St. Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 12/26/68 | | Sunset Cemetery | | Clarksburg Harrison Co. W. Va. | | | |
| 24. FUNERAL DIRECTOR Hagerstown | | | | ADDRESS Md. | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Andrew K. Coffman Funeral Home Inc | | | | | | DEC 27 1968 | | J. Charles Judge | |

10438

Stephen Michael



Barryland Association
Camp Ritchie
John E. Wagner
Camp Ritchie

John E. Wagner
Camp Ritchie

John E. Wagner
Camp Ritchie

John E. Wagner
Camp Ritchie

John E. Wagner
Camp Ritchie

John E. Wagner
Camp Ritchie

John E. Wagner
Camp Ritchie

John E. Wagner
Camp Ritchie

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18427 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18440 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--|-----------------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last | | | | | | | | | | 2a. DATE OF DEATH Month Day Year | | | | | | | | | | 2b. HOUR P.M. | | | | | | | | | |
| Edgar M. Weber | | | | | | | | | | Dec. 3, 1968 | | | | | | | | | | 11:45 P.M. | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| Male | | | | | white | | | | | 5-130/1899 | | | | | 67 YRS. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | |
| Wash. Co. Md. | | | | | U.S.A. | | | | | | | | | | Washington Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Hagerstown | | | | | Wash. Co. Hosp. | | | | | | | | | | Retired Farmer | | | | | Farm | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Md. | | | | | Wash. | | | | | Smithsburg | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | Rd. 2 Smithsburg, Md. | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| Benjamin Weber | | | | | Anna (Martin) Weber | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | |
| | | | | | 217-42-9253 | | | | | Mrs. Edna Weber - Smithsburg, Md. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema | | | | | | | | | | | | | | | 2 hrs | | | | | | | | | | | | | | |
| 1890 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 180 X | | | | | | | | | | | | | | | 3 mo | | | | | | | | | | | | | | |
| (b) Melioidosis Ca of Lung | | | | | | | | | | | | | | | 6 mo | | | | | | | | | | | | | | |
| (c) Carcinoma of G Kidney | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Heart Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1968, to Dec 3, 1968, that (I) (we) last saw the deceased alive on Dec 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | |
| Donald E. Martin M.D. | | | | | | | | | | | | | | | 12/4/68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| DR. DONALD E. MARTIN | | | | | | | | | | | | | | | Cleveland * Cannon Ave - Hagerstown, Md. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Burial | | | | | 12/7/68 | | | | | Reft Ch. Cem. | | | | | Cearloss, Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| A.E. Munnich - Greencastle, Pa. | | | | | | | | | | | | | | | DEC 6 1968 | | | | | Charles Yunge | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|--|--|--------------------------------|---------------|--|
| 1. DECEASED-NAME (Type or print) | | | First Cora | | | Middle Irene | | | Last Zimmerman | | | 2a. DATE OF DEATH Month December Day 14 Year 1968 | | | 2b. HOUR M | |
| 3. SEX female | | | 4. RACE white | | | 5. DATE OF BIRTH 11-13-1882 | | | 6. AGE (In years last birthday) 86 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Washington | | | Md. | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 811 S. Potomac, St. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Wash. | | | 13c. CITY OR TOWN Hagerstown | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 811 S. Potomac, St. | | | | |
| 14. FATHER'S NAME First Middle Last Luther M. Zimmerman | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Louisa Saltsgiver | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no | | | 16b. SOCIAL SECURITY NO. None | | | 17. INFORMANT Address Mr. Adelbert Burton Hagerstown, Md. | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 4310 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs years years | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 331X | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 19, 1968 , to Dec 14, 1968 , that (I) (we) lost saw the deceased alive on 13 Dec 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Charles Hoochlander M.D. | | | | | | | | | | | | 22c. DATE SIGNED 12/16/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Elder S Hoochlander | | | | | | 22e. ADDRESS Hagerstown Md | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 12-16-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md. | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 18 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | |

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